

MORE THAN A ONE-TIME TRAINING:

BUILDING ANTI-RACIST CAPACITY WITH CALIFORNIA'S PERINATAL HEALTHCARE PROVIDERS

IMPLEMENTATION ANALYSIS OF CA SB-464

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on behalf of UCSF California Preterm Birth Initiative

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EXECUTIVE SUMMARY

A recent White House announcement made in April 2021 recognized the national Black maternal health crisis, proclaiming April 11-17 Black Maternal Health week in acknowledgement of the fact that the U.S. maternal mortality rates are among the highest amongst other economically advantaged counties, and are especially high for Black and Native American women and birthing people. The brief notes that Black women are two-to three times more likely to die of pregnancy-related causes than other women regardless of their income or education levels. The Biden-Harris administration released steps they are taking at the federal level to address racial disparities in reproductive health outcomes, including a newly proposed investment of “\$200 million to implement implicit bias training for healthcare providers” (WH Fact Sheet, April 2021). This federal proposal to invest in provider training around implicit bias reflects an urgent conversation being had at the state-level around how to address racial inequities in access to quality and respectful perinatal healthcare, and obstetric racism.

One such conversation is taking place in California around the implementation of [the California Dignity in Pregnancy and Childbirth Act](#) (Mitchell, 2019) or [SB-464](#). This report attempts to uncover how hospitals and clinical providers are implementing the required implicit bias training mandated by SB-464, as well as broad facilitators and challenges to implicit bias and anti-racist workforce capacity-building with California’s perinatal healthcare workforce. Through key informant interviews with individuals working across the birth equity and perinatal care sector, and a digital survey targeting hospital perinatal staff the following facilitators and challenges to SB-464 implementation emerged:

COMMON FACILITATORS FOR IMPLEMENTATION

- 1. Integration:** Go beyond a one-time training requirement to include anti-racist strategies, including but not limited to implicit bias interruption, ongoing education about historical and present-day structural racism, cultural humility, structural competency, and personal reflection. Integrate this into workplace policies, clinical practice, and organizational culture.
- 2. Evaluation:** Evaluate implicit bias training and other anti-racist capacity-building trainings with respect to patient-reported experience, alongside biomedical data disaggregated by race/ethnicity.
- 3. Black Leadership:** Authentically listen to and follow Black leadership such as patients, community members, birth equity advocates, birthworkers and healthcare providers, and local community-based organizations.

4. **Support BIPOC birthworkers:** Support BIPOC perinatal care providers and birthworkers, and cultivate equitable pipelines to diversify the workforce.
5. **Staff Champion:** Be or support a staff champion, that can serve as a bridge from the clinical setting to public health agencies or community-based organizations.
6. **Transparency:** Be transparent in internal and external communication about racism in the clinical setting and racism as a root cause for reproductive health disparities.
7. **Funding:** Dedicate ongoing funding to anti-racist capacity-building, and prioritize contracting local birth equity or Black-led community-based organizations for training.

COMMON BARRIERS TO IMPLEMENTATION

Organizational & Cultural barriers to Anti-Racist Workforce Capacity Building:

1. **Slow release:** Largely due to COVID-19, the release of implicit bias training modules has been delayed.
2. **Constraints on Human Capacity:** Both healthcare workers and community-based organizations experience burnout and constraints on their staffing capacity.
3. **Lack of Organizational Awareness or Buy-in:** Perinatal staff may not be aware of the bill requirements or may exhibit resistance against the bill's intent in various forms including but not limited to dismissal, white fragility, and enlightenment hubris.
4. **Healthcare System:** The U.S. healthcare system represents a fractured continuum of care with disjointed services oriented around profit-seeking behavior, working against patient-centric modalities of care.
5. **Traditional Medical Education:** Traditional medical education is not anti-oppressive or patient-centered, but rather is focused around symptom alleviation, and often perpetuates racist stereotypes.

Barriers to SB-464 Implementation due to Bill Language:

1. **Funds:** There is no funding attached to the bill requirements.
2. **HMOs:** There is currently no formal guidance for the role that HMOs/Payers can play.
3. **Confusion around vendor:** There is a lack of clarity around which vendor or who should create and facilitate training.
4. **No Compliance Measure:** There is a lack of formal oversight, enforcement or incentive measures for hospitals and clinics to implement training.

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INTRODUCTION

THE CLIENT

The California PreTerm Birth Initiative (PTBi) lives at the intersection of research, community partnerships, and education to create positive change for Black and Brown families. They represent a collaborative of obstetric researchers, doctors, nurses, birth equity advocates, doulas, and impacted community members. Their mission is to eliminate racial disparities in preterm birth and improve health outcomes for babies born too soon, through research, partnerships and education grounded in community wisdom.

SITUATING THE AUTHOR

Annie Dade is a graduate student researcher at the Goldman School of public policy, University of California, Berkeley. She comes to this work with a deep commitment to advancing anti-racist and equitable strategies to support care work and maternal and child wellbeing across the life continuum, with a research background in qualitative and participatory methods. As a white woman who has never experienced obstetric racism or given birth, and as a professional who has never worked in a healthcare clinical setting, she approaches this topic with humility and a desire to uplift the voices of those who have been working to advance dignity and respectful care for Black birthing families.

PROBLEM OVERVIEW

In an effort to address obstetric racism and racial disparities in birthing and maternal health outcomes, particularly for Black mothers and birthing people, the California Dignity in Pregnancy and Childbirth Act or SB-464 (Mitchell, 2019) made the following statewide mandates:

- 1) Required implicit bias training for all perinatal and obstetric inpatient providers,
- 2) Improved death certificate reporting to get a more accurate understanding of mortality due to pregnancy-related factors,
- 3) Requires CDPH reporting of maternal mortality/morbidity by race and other determinants by region,
- 4) Required patient education upon admission about their right to be free of discrimination and how to file a complaint if they racial discrimination during their healthcare experience

However, too little is understood about the implementation of SB-464 particularly with regards to evaluating the impact of implicit bias training for healthcare providers on the experience of perinatal care and birthing outcomes for Black birthing families in California. The bill itself lacks appropriated funds for training, guidance on who within a health organization should implement training, guidance on how to select a vendor for training, and enforcement measures to ensure compliance.

This project, on behalf of PTBi, sought to understand the landscape of bill implementation across the state; in particular by learning how hospitals and providers are implementing the mandatory implicit bias training, what barriers exist, and what conditions or “promising practices” facilitate effective implementation. Furthermore, this project was an inquiry into how anti-racist workforce training is being evaluated with regards to meaningful outcomes for Black birthing families, and how hospital accountability to Black birthing families could be operationalized.

This report draws on participatory research design and qualitative research methods. Data collection involved:

- ◇ Thirty-three key informant interviews;
- ◇ Four-week, forty-two question digital survey of perinatal healthcare providers and/or Labor & Delivery Department staff;
- ◇ Literature review on obstetric racism, racial health disparities in maternal mortality, evidence-based strategies for mitigating harm of implicit bias in medical and perinatal healthcare;
- ◇ Document review of online resources (e.g. birth equity training, public contracts, city, county, and state public health and perinatal equity initiative department websites).

After providing deeper context around the California maternal healthcare crisis and a literature review into obstetric racism and implicit bias training, this report will share findings from a survey targeting hospital staff as well as qualitative data gleaned from the survey and interviews around facilitators and challenges for implementing SB-464 and related workforce capacity-building trainings.

CONTEXT: MATERNAL HEALTH CRISIS IMPACTS BLACK PATIENTS

There is a maternal health crisis in the US. Most maternal deaths are preventable, and yet the U.S. has the highest maternal mortality rate among high-income countries (Tikkanen, 2020). Despite growing awareness of this pressing issue, maternal mortality rates increased in the U.S. by almost twenty-seven percent from 2000-2014 (Macdorman, 2016). Looking at this reality for mothers and birthing people¹ by race and ethnicity paints an even more devastating picture. In California where the maternal mortality rate is a third of the national average, and has decreased by fifty-five percent between 2006 and 2013, Black women and birthing people are dying at over three times the rate of white women, are more likely to experience a preterm birth, and more likely to experience a low-risk, first-birth Cesarean²-- six percentage points above the 2020 Healthy People's Target (Joynt, 2019). These racial health disparities for Black mothers and birthing people cannot be fully explained by different access to education or healthcare or differing income levels (Taylor, J. K., 2020). These disparities must be viewed as far more than data points; they reflect unimaginable tragedies for birthing families and preventable harm.

Substantial evidence supports the understanding that racism, not race, is the underlying mechanism by which Black mothers and birthing people are experiencing negative, at times fatal, birthing outcomes. *Racism as a Root Cause* (Malawa et. al, 2021), *Structural Competency* (Metzl & Hansen, 2013), and *Reproductive Justice* will serve as guiding frameworks for this report.

RACISM AS A ROOT CAUSE

This framework situates racism, not race of the patient, as the mechanism by which Black patients and other patients of color experience negative health outcomes. Understanding racism as a root cause of health disparities requires dismantling the pathways by which racism affects maternal health at every level (Malawa et. al, 2021). Racism operates at the

¹ Not all birthing people identify as women; many transgender, nonbinary, and gender nonconforming individuals give birth, and may experience intersectional oppression, interpersonal bias, and racism as a result of their racial and gender identities. In this report, I will use Black mothers and birthing people, unless citing a source that distinctly references women or mothers. I will often use the non gender-inclusive terms: maternal healthcare or maternal disparities as the majority of literature and programs are oriented around this terminology.

² Low-risk, first birth cesarean birth rate represents the percentage of cesarean deliveries among first-time mothers delivering a single baby in a head-down position after 37 weeks gestational age. The technical term for this measure is the nulliparous, term, singleton, vertex (NTSV) cesarean birth rate. The US government's Healthy People 2020 initiative establishes science-based 10-year national objectives for improving the health of all Americans (see www.healthypeople.gov).

internalized, interpersonal, institutional, and structural levels (Jones, C., 2000). Structural racism is defined as “a system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity” (Aspen Institute, 2021). Structural racism affects the health of Black birthing families through myriad racist policies and institutions. The racial disparities in sickness and mortality laid bare by the COVID-19 pandemic reflect racism embedded in U.S. housing, education, economic, food, and healthcare systems. Historic and contemporary policies such as redlining, racist “tough on crime” policies that resulted in over-incarceration of Black and Brown communities, and targeted voter suppression continue a legacy of segregation, disenfranchisement, and underinvestment in Black communities and other communities of color that impact health outcomes.

The RRC framework also addresses racialized power dynamics within healthcare organizations and public health programs. Often programs that are supposed to explicitly serve or benefit a community experiencing racism do not address underlying power structures embedded in the program, explicitly addressing who gets funding to do the work and who ultimately has decision-making power over the interventions employed. The Racism as a Root Cause approach requires a strategy for building capacity and empowering community leaders to develop and implement the strategies that serve their own community (Malawa, Z., Gaarde, J., & Spellman, S., 2021)

STRUCTURAL COMPETENCY

Structural competency is a new framework in healthcare that requires medical training to understand systemic racism, among other forms of institutional oppression, as upstream social determinants of health for an individual. This framework challenges the dominant framework that places the burden and judgement of negative health on an individual Black birthing patient, or dismantling what researchers call the “Mother Blame narrative” (Scott, K. A., Britton, L., & McLemore, M. R., 2019).

Structural Competency is defined as:

“The trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases (e.g., depression, hypertension, obesity, smoking, medication “non-compliance,” trauma, psychosis) also represent the downstream implications of a number of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health” (Metzl & Hansen, 2013).

Providers who ostensibly hope to provide care to their patients report this as a growth area. For example, eighty-five percent of primary care providers and pediatricians polled in a 2011 Robert Wood Johnson survey agreed with the statement that “unmet social needs are leading

directly to worse health for all Americans" while agreeing that they did not "feel confident in their capacity to meet their patients' social needs," and that their inability to do so "impedes their ability to provide care" (Metzl & Hansen, 2013). Structural Competency requires understanding systemic racism, and ultimately may change the way we train healthcare providers and structure healthcare programs.

REPRODUCTIVE JUSTICE

Drawing on a legacy of trans, Indigenous and women of color-led advocacy, Sister Song is a leading reproductive justice advocacy organization. Beginning from a place of Black-women led epistemology, they define reproductive justice as "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities". Understanding maternal health through a reproductive justice lens requires understanding structural racism exists in many domains that affect a parent and their child's livelihood including but not limited to housing, education, environment, police violence, and criminal-legal system involvement.

CONTEXT: SB-464

In October, 2019 Governor Newsom signed the "California Dignity in Pregnancy and Childbirth Act" (SB-464) into law, which went into effect January 1, 2020. Shortly after the requirement went into place the COVID-19 pandemic imposed severe constraints on healthcare organizations, frontline healthcare workers, and public health agencies, while also exposing the structural inequities in our healthcare system by disproportionately impacting Black communities and other communities of color. While the bill has been in effect now for over a year, hospitals and clinics are still determining how to implement it, and advocates are concerned that the implementation is not being meaningfully tied to improved health outcomes and birthing experiences for Black patients.

Most significantly, SB-464:

- ◇ Requires hospitals and facilities providing perinatal care to train all providers on implicit bias;
- ◇ Improves requirements around death certificate reporting in order to provide a more accurate understanding of mortality due to pregnancy-related factors;
- ◇ Improves regional reporting of maternal mortality/morbidity by race and other determinants in order to facilitate transparency and accountability;
- ◇ Requires patient education about ways to report racial discrimination during their healthcare experience.

State Senator Holly Mitchell authored the bill, and it was sponsored by Black Women for Wellness, NARAL Pro-Choice America, Act for Women and Girls, California Nurses Association, and Western Center on Law & Poverty amongst other groups.

"With the maternal mortality rate for Black women still three to four times the rate than for white women, health care providers must start learning about and discussing the impact of bias on their work. We know that implicit bias training is just one piece if we truly want to eliminate racism in health care, but it is an important and necessary step to ensure all patients are treated with dignity and respect."

-Jen Flory, Policy Advocate, Western Center on Law & Poverty, one of the co-sponsors of SB-464

Another co-sponsor of the bill, the California Nurse-Midwives Association provided a comment on the bill's intent:

"As health care providers, it was an honor to co-sponsor SB 464 and help shift the conversation away from blaming the patient for rising disparities, and push the system and institutions toward personal responsibility in improving birth outcomes for Black birthing people, indigenous, and all people of color. We also sponsored SB-464 in order to mandate that regional maternal mortality and morbidity be reported on a regular basis and also disaggregated by race and ethnicity so that researchers, clinicians, and policy makers alike can begin to more clearly see the problem at hand, and the strategies for improvement."

-Holly Smith, CNM, Health Policy Chair for CA Nurse-Midwives Association

As these co-sponsors note, the bill was intended to shift responsibility for racial disparities in birth outcomes on to healthcare systems, and requires implicit bias training as just one tool to do so. The following section will provide an overview of the implicit bias requirement and provide context about the perinatal healthcare landscape in California, necessary to understand in order to implement the training requirement and the broader intent of the bill.

IMPLICIT BIAS TRAINING REQUIREMENT:

The bill requires licensed hospitals and other facilities providing perinatal care in California to train all perinatal care providers, and offer training to physicians not on staff, as well as provide certification of training completion upon request. Additional refresher courses are required every two years thereafter. The bill includes ten provisions for trainings that a module must include in order to be compliant:

SB-464 TRAINING REQUIREMENTS:

- ◇ Identification of previous or current unconscious biases and misinformation.
- ◇ Identification of personal, interpersonal, institutional, structural, and cultural barriers to inclusion.
- ◇ Corrective measures to decrease implicit bias at the interpersonal and institutional levels, including ongoing policies and practices for that purpose.
- ◇ Information on the effects, including, but not limited to, ongoing personal effects, of historical and contemporary exclusion and oppression of minority communities.
- ◇ Information about cultural identity across racial or ethnic groups.
- ◇ Information about communicating more effectively across identities, including racial, ethnic, religious, and gender identities.
- ◇ Discussion on power dynamics and organizational decision-making.
- ◇ Discussion on health inequities within the perinatal care field, including information on how implicit bias impacts maternal and infant health outcomes.
- ◇ Perspectives of diverse, local constituency groups and experts on particular racial, identity, cultural, and provider-community relations issues in the community.
- ◇ Information on reproductive justice.

Source: CA Dignity in Pregnancy and Childbirth Act. SB-464. (Mitchell, 2019).
<https://legiscan.com/CA/text/SB464/2019>

CONTEXT: CALIFORNIA PERINATAL HEALTHCARE LANDSCAPE & SB-464

CALIFORNIA BIRTHS BY SETTING: WHERE SHOULD TRAINING TAKE PLACE?

In 2018, nearly all births in California occurred in a hospital (Joynt, 2019), so implementing birth equity interventions requires understanding the landscape of birthing hospitals. There were 367 General Acute Care Hospitals with 6,763 licensed perinatal beds as of 2017 (California Healthcare Almanac, 2019). The California Maternal Quality Care Collaborative counts around 213 hospitals in its membership (Maternal Data Center, Slide deck, 4-16-2020), covering approximately ninety-six percent of California's delivery volume (CMQCC Annual Report, 2020). This report will focus primarily on hospital-based implicit bias and anti-racist training; additional research can be undertaken to understand training implementation across clinics and alternate birthing centers.

Within the hospital system, hospitals vary by funding and ownership structure, and in turn by the demographics of patients that they serve. In the US, fifty-four percent of community hospitals are not-for-profit, twenty-four percent are for-profit, nineteen percent are state and local government owned (Fast Facts on US Hospitals, 2021). California's twenty-one public health care systems include county-affiliated systems and the five University of California academic medical centers. According to the California Association of Public Hospitals and Health Systems' website, these health systems represent just six percent of all hospitals in the state, but operate in fifteen counties where eighty percent of the state's population lives, providing forty percent of all hospital care to California residents who remain uninsured and thirty-five percent of all hospital care to Medi-Cal beneficiaries in the communities they serve. Given that public hospitals serve such population dense areas, particularly with populations that face many economic and social barriers to access to health insurance and quality care, it would be prudent to target implicit bias interventions in these hospitals.

CALIFORNIA BIRTHS BY PRACTITIONER: WHO NEEDS TO BE TRAINED?

Outside of the hospital system, California residents may give birth at community-based clinics or alternative birthing centers. The majority of births in alternative birth centers or home-births are delivered by a practitioner other than an MD, such as a midwife, a paramedic, or unstated (Kwong, C. et. al, 2019).

The vast majority of births in California are delivered by a physician (MD). That said, the hospital-based clinicians who often have **the most frequent touchpoints with birthing and pregnant patients are the nursing staff.** Targeted interventions (i.e. implicit bias training)

should cover the entire clinical team, but attention should be paid to the different roles and interactions clinical staff may have with birthing patients.

Table 1: Number of Annual Births, by Practitioner, California, 2017

Doctor of Medicine (MD)	386,646	~82%
Doctor of Osteopathy (DO)	49,512	~10.5%
Nurse-Midwife (NM)	27,414	~6%
Licensed Midwife (LM)	2,908	~0.5%
Other (e.g. Paramedic)	4,759	~1%
Unknown or not stated	394	~<1%

Source Table 1: (United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Health Statistics, Division of Vital Statistics, Natality Public-Use Data 2007–2017, on [CDC WONDER](#) Online Database, October 2018.):

WORKFORCE DEMOGRAPHICS

As previously noted, the majority of OB/GYNs and Nurse practitioners in the US are white (Martin et. al, 2013) (National council of State Boards of Nursing, 2017). Nearly all nurse-midwives (CNM) in California are female, and the workforce is predominantly white. Less than six percent of CNMs are Black, which is higher compared with many other health professions, while still under-represented as compared to the general state population (Kwong, C. et. al, 2019) Addressing workforce diversity by supporting existing Black, Indigenous, and practitioners of color (BIPOC), while cultivating professional pipelines for BIPOC healthcare providers is of paramount importance.

LITERATURE REVIEW: OBSTETRIC RACISM & IMPLICIT BIAS TRAINING

HOW HAS HISTORICAL RACISM IMPACTED THE FIELD OF OBSTETRICS AND PROVIDER-PATIENT RELATIONSHIPS?

According to a 2016 analysis of medical professions, under-represented minorities make up less than twenty percent of OB/GYN physicians in the US, while nearly half of US births in 2013 were people of color (Martin et. al, 2013). A 2017 survey conducted by the National Council of State Boards of Nursing found that nurses are mostly women and eighty percent white. Given that the vast majority of nursing staff and OB/GYNs are white, it is crucial that an understanding of medical and obstetric racism be understood alongside historical and current forms of white supremacist institutions, and critical race studies of whiteness.

Historian, Dr. Deirdre Cooper Owens, documents in her book *Medical Bondage* the racist history of the field of gynecology and the ways in which the practice of white male doctors considered pioneers in this field was deeply entwined with the institution of slavery. Nineteenth century doctors, John Peter Mettauer, James Marion Sims, and Nathan Bozeman performed non-consensual pelvic exams, experimental cesarean sections, and other invasive and painful procedures on Black women who were enslaved. Three of the women that James Marion Sims violently operated on were named Lucy, Anarcha, and Betsy.

Sims and other white doctors', disseminated racist ideas about Black women's bodies and pain tolerance; ideas that permeate modern-day anti-Black racist stereotypes about Black patients. A 2015 Pearson Nursing Textbook stated that "Blacks report higher pain intensity than other cultures" (Nursing, A Concepts Based Approach to Learning, 2015). The discounting of Black people's physical pain is undergirded by the racist assumption that Black bodies do not feel as much pain as white bodies, a long-held stereotype used to justify the violence and brutality of slavery. Making this harmful insinuation that the pain being reported by a Black patient is in fact an over-statement, would lead practitioners to under-treat Black patients for pain— a form of medical racism that has been documented by studies of bias in healthcare. The traumatic history of gynecology, along with other well-documented examples of medical racism like the Tuskegee Syphilis Trial, and countless lesser-known instances may lead Black patients to experience distrust of white medical providers and the healthcare system (Roberts, 2012; Penner et. al, 2014) Pulling on critical race studies of whiteness and deep work around racial healing, Dr. Monique LeSarre, Psy.D., and Executive Director of the Rafiki Coalition for Health and Wellness offers a model for what she terms the "white soul wound". White providers must confront the historical and current day underpinnings of obstetric racism and work through any feelings of shame, depression, anxiety, or disavowal of white privilege as a defense

mechanism, in order to be able to provide appropriate and respectful care to Black patients (LeSarre, M., 2021).

HOW DOES STRUCTURAL RACISM IMPACT BLACK MATERNAL HEALTH AND BIRTHING OUTCOMES?

One study of Black birthing patients in Oakland, California found that approximately fifty-two percent of pregnant and early post-partum Black women lived in “deprived” or under resourced neighborhoods within Oakland. The majority of participants reported experiencing racial discrimination in at least one of the following domains: education, employment, housing, access to healthcare. Living in a highly segregated and “deprived” neighborhood was correlated with experiencing racism across several domains. This points to the high level of chronic stressors due to structural racism across sectors that many Black birthing patients face (Chambers, B. D., et. al, 2020). The chronic stressors imposed by structural racism have been shown to be associated with negative maternal and infant health outcomes either directly through prenatal stress-related physiological changes on the developing fetus, or indirectly through the effects of prenatal stress on maternal health and pregnancy outcome which, in turn, affect infant health and development (Coussons-Read, M. E., 2013). For example, exposure to racism-in particular anti-Black racism, is correlated with low birthweight in Black/African-American babies (Collins et. al, 2004), (Mendez, D. et. al, 2014). And a recent study demonstrated that experiencing a police killing of a Black person in one’s neighborhood during pregnancy can increase the risk of preterm birth among Black women and birthing people (Goin, D.E et. al., 2021).

HOW DOES INTERPERSONAL RACISM IMPACT BLACK MATERNAL HEALTH AND BIRTHING OUTCOMES?

Beyond the impacts of structural racism on health outcomes, there is evidence that healthcare provider bias and differentiating quality of care leads to disparities in the healthcare Black patients receive. Penner et. al (2014) proposed a model by which racial bias leads to poorer medical treatment of Black Americans through three pathways. The first is the persistent psychological and physical stress of experiencing racism which has been directly linked to negative health outcomes. The second is by way of implicit bias on the part of the healthcare provider that may lead to different perceptions, assessments, and ultimately decisions about the course of treatment. Lastly, racial bias negatively affects communication and patient-provider relationships, resulting in disparities in the outcomes of medical interactions.

Studies have shown that healthcare providers are more likely to underestimate pain levels reported by Black patients (Staten, Lisa et. al, 2007), more likely to conduct illicit drug tests on Black parents and their newborns (Kunins, H. et al, 2007), less likely to prescribe pain medication (Sabin, 2012) and less likely to recommend clot-reducing medication to Black patients as compared to white patients (Green et. al, 2007). A survey of Black mothers and birthing people found that participants in California were more likely to report explicit discrimination from birthing staff, barriers in communication with healthcare providers, or disregard from delivery staff for their birthing wishes during their perinatal and postpartum healthcare interactions (Listening to Black Mothers in California, 2018).

Another report found common themes across the birthing experiences of over one hundred Black birthing patients in California (Oparah, J., et. al, 2018). Participants reported the provider relationship as a source of stress due to four key areas:

- ◇ Refusal to listen to women’s wisdom about their bodies;
- ◇ Not respecting women’s boundaries or bodily autonomy;
- ◇ Stereotyping based on race, class, age, sexual orientation and marital status;
- ◇ Suppressing advocacy and self-advocacy.

More than half (55%) of the patients in the study experienced anxiety and fear about the process of birth, labor pain, and the possibility of death and disablement for them or their baby. Many participants reported receiving interventions without consent, such as forced labor induction, pressure to have intravenous pain medication or unnecessary C-section, or being denied a range of comfortable movement or birthing positions. When asked to identify characteristics that were important to building positive relationships with medical professionals, participants indicated the following three areas:

- ◇ Psychological support and reassurance in relation to fears and pain related to pregnancy and childbirth;
- ◇ Respect for the pregnant individuals’ values, beliefs and choices;
- ◇ Competency and effectiveness.

WHAT EVIDENCE-BASED INTERVENTIONS FOR IMPLICIT BIAS EXIST?

Implicit bias among healthcare professionals refers to “associations outside conscious awareness that lead to a negative evaluation of a person on the basis of characteristics such as

race or gender” (FitzGerald, C., & Hurst, S., 2017). Provider implicit bias directly produces racial disparities in healthcare (Byrne, A., & Tanesini, A., 2015). Research has shed light on some of the concrete ways in which Physicians who exhibit higher measurable bias treat Black patients differently than white patients; with Black patients they tend to speak faster, speak more, have shorter visits, and tend to be less patient-centered (Cooper et al., 2012; Hagiwara et al., 2013). Implicit bias can be interrupted through various interventions- mostly through ongoing educational training, deep social-political consciousness work, and providing concrete tools to interrupt bias.

IMPLICIT BIAS TRAINING MUST CONNECT TO PARTICIPANTS’ VALUES.

The efficacy of interventions is dependent on the content and sustained exposure of the training. Research has shown that people with high internal motivation (i.e. motivated by a belief in equal treatment or social justice values) were more successful in reducing implicit bias compared to people who were externally motivated (i.e. concerned with others’ evaluation of them). Thus implicit bias training is most effective when it is directly connected to an individual’s values. (Devine et. al, 2002) (Hagiwara et. al, 2020)

IMPLICIT BIAS TRAINING SHOULD PROVIDE STRATEGIES BEYOND AWARENESS.

Evidence points to the necessity of providing specific strategies to override the habitual response of implicit bias. One program that taught college students about five evidence-based strategies for reducing implicit bias resulted in lower implicit racial prejudice, as measured by an implicit association test eight weeks after the intervention (Devine et. al, 2012). Research also shows that implicit bias training that only focuses on awareness but does not teach concrete strategies for health care providers to interrupt bias can actually have harmful effects. For example, increased awareness of one’s own bias without specific strategies can result in increased anxiety and avoidance of others that are perceived to be members of a marginalized group. It could also result in over-compensation or being overly friendly which could be perceived by members of marginalized social groups as inauthentic.

EVIDENCE-BASED STRATEGIES TO INTERRUPT IMPLICIT BIAS:

(PENNER ET. AL, 2014), (DEVINE ET. AL, 2013) (AFULANI ET. AL, 2017):

- ◇ **Patient Individuation:** Seeing each patient as a unique individual rather than mainly as a representative of some racial or social group;

- ◇ **Patient-Centered Care:** Person or Patient-centered maternity care refers to care during childbirth that is respectful and responsive to individual patients, and their families' preferences, needs, and values. Person-centered maternity care emphasizes the quality of patient experience. Tools involve sharing decision-making with patients and spending time to create a positive relationship between patient and provider.
- ◇ **Creating ingroup shared goals:** Using messages and strategies to create and communicate shared goals and team values. This could include openly discussing shared goals and using the language of "we" and "us" when talking about the treatment plan.
- ◇ **Counter-Stereotyping:** Learning the historic and contemporary ways in which stereotypes are held against Black people such as the "Angry Black Woman" stereotype. Replace with positive, realistic, and multi-dimensional portrayals (could be visual, verbal, or cognitive) of Black women and Black people in all their humanity.
- ◇ **Perspective Taking:** Find creative and respectful- not appropriative or tokenizing- ways to learn from and empathize with another person's experience

IMPLICIT BIAS MITIGATION MUST BE SUSTAINED BY WORKPLACE POLICIES THAT PROVIDE CHECKPOINTS AND ONGOING OPPORTUNITIES TO INTERRUPT BIAS AT A PERSONAL AND GROUP LEVEL.

Beyond intervention at the individual level, there are workplace policies and practices that can mitigate opportunities for implicit bias to influence decision-making and communication. Implicit bias likely exerts a stronger influence on an individuals' thoughts and actions when they are experiencing time pressure, high cognitive demand, or fatigue, and when there is little oversight on their thoughts or actions (Penner et. al 2014). Hospital and clinical settings are rapidly paced, often under-staffed, and require practitioners to juggle multiple demands on their cognitive capacities. This high-pressure, time constrained environment works against the individual implementing strategies to interrupt unconscious bias. Workplace policies that invite spaciousness, checkpoints, oversight, relationship-building, and ongoing opportunities for reflection on racial identity and power dynamics will increase the effectiveness of individualized strategies.

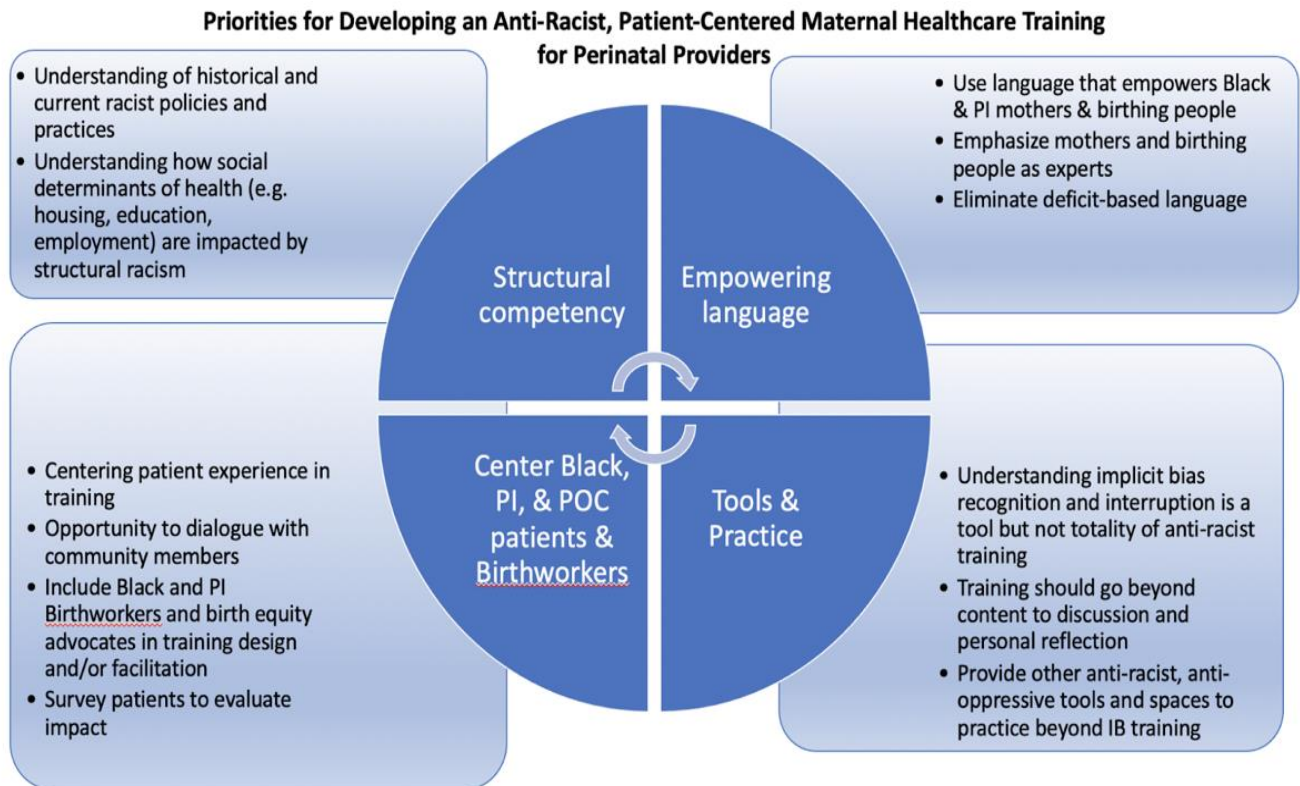
METHODOLOGY & RESEARCH QUESTIONS:

This research into SB-464 implementation is necessarily grounded in the expertise of the PTBi Community Advisory Board Experts who are Black/African-American and Pacific Islander birth equity leaders and birth workers, many of whom have experienced obstetric racism during their own pregnancy and childbirth. Grounded in Community-Based Participatory Action Research methodology, the SB-464 research questions grew out of priorities set by the community advisory board experts.

PTBI CAB PRIORITIES FOR SB-464 IMPLEMENTATION

“Best practice” can take different meanings depending on positionality and relationship to a problem. In order to orient implementation research around priorities set by those most proximate to Black maternal health, I conducted interviews with PTBi Community Advisory Board Experts and gathered responses to the following questions.

- ◇ *What would you prioritize in a racial equity training for perinatal healthcare providers?*
- ◇ *How would you center accountability to Black patients in a racial equity training program?*



DEVELOPING RESEARCH QUESTIONS

Using these priorities to guide my research, as well as working understandings of implicit bias in healthcare from the literature review, I developed interview guides (See Appendix I) oriented toward four audiences of key informant interviews:

1. Perinatal providers or hospital staff
2. Vendors of SB-464 compliant training
3. State, County, or City Public health department staff
4. Birth equity advocates or community-based organizations

In addition to interviews, I sent a digital survey to labor and delivery or perinatal staff across the state. I targeted my outreach to hospitals who served the highest number of Black and African-American identifying birthing patients in 2019 (both in terms of discrete patients and percentage). I made direct phone calls to twenty-four hospitals- of those hospitals fewer than half said they were willing to answer questions over the phone or share the digital survey with their department manager. I also disseminated the digital survey to the Perinatal Equity Initiative county directors to share with hospitals in their jurisdiction, to California Maternal Quality Care Collaborative (CMQCC) to share with hospitals participating in their birth equity collaborative, to Cherished Futures for Black Moms and Babies to share with their five partner hospitals in LA, as well as to other key informants working in perinatal healthcare across the state.

SUMMARY OF INTERVIEW PARTICIPANTS

Table 2: Summary of interview participants

#	Type
8	Public health department employee (state, county, city)
7	Nurse or nurse-midwife (CNM)
6	PTBi Community Advisory Board member

5	CBOs working on reproductive justice or birth equity
3	Vendor orgs of SB-464 compliant training
2	Obstetrics and reproductive health researchers
1	Hospital administrator
1	HMO/Payer
33	TOTAL INTERVIEWS

REPRESENTED GEOGRAPHIES: Statewide, Riverside county, LA (city and county), Alameda county, Oakland, San Francisco, San Joaquin County, San Diego, Fresno

See Appendix I for list of interviewees by name.

OVERVIEW OF TRAINING OFFERINGS

The following section will provide an overview of the most common SB-464 compliant trainings that are being offered and implemented in hospitals across California. Trainings will be compared across the following domains: length, format, cost, evaluation, content. Appendix III provides a summary table of registrations numbers for each of these training modules as of early April (numbers that will be out-of-date quickly as more hospitals enroll).

MARCH OF DIMES & QUALITY INTERACTIONS

Overview: This training was developed through a partnership between March of Dimes, a national organization that supports research and policy advocacy for infant and maternal health, and Quality Interactions, a provider for cultural competency training in the healthcare industry.³

Length: Approx. one hour to complete the five lessons



Format: Online e-module that you can do on computer, phone, or tablet.

Additional live three-to-four-hour training with a national March of Dimes facilitator that provides in-depth local data and opportunities for breakout groups and discussion. This can be provided for up to one hundred participants.

Cost: An individual account is \$50, but contracts can vary with the volume of seats acquired. The live training is \$11,000 for up to one hundred seats. In LA and the Bay Area, March of Dimes has partnered with Anthem Health Equity to provide training for partner hospitals in LA and the Bay Area.

Evaluation: End-of-Course survey for participants which asks questions like: "Are you going to change one or more aspects of your practice after this training?" and "Do you think this info is scientifically sound?" At the end, each individual participant will get a certificate, but QI also has the ability to send a learner's report to any organization that purchases an account for hospitals that are tracking their staff completion.

Content: The five lessons are topically:

- ◇ Disparities in maternal healthcare with a focus on Black/African-American patients

³ Image source: <https://www.qualityinteractions.com/implicit-bias-training-mhc-orgs?>

- ◇ Implicit bias in healthcare
- ◇ Structural racism in the US
- ◇ Strategies to mitigate implicit bias
- ◇ Creating culture of equity

Number of Accounts: As a conversation with the Director of Business Development in February, 2021, 25-30 individual and 8 organizational accounts had been purchased in California. Organizational accounts can be up to 100 “seats” on behalf of hospitals or health plans.

DIVERSITY SCIENCE

Overview: Diversity Science and project director, Dr. Rachel Hardeman, PhD, MPH, created three interactive e-learning modules for perinatal providers that satisfies the SB-464 training requirements.⁴

Length: Approx. one hour
(three 15-30 minute modules)

Format: Online through Diversity Science’s platform or can be accessed by uploading course files onto an organization’s own learning management system

Cost: Free, funded by a grant from the California Health Care Foundation.



Evaluation: There is no formal pre/post survey, but the training includes a number of quizzes and self-reflection activities within the course that serve as knowledge checks. These provide spaces for people to self-evaluate what they have learned and how they would integrate into practice. The training platform also has a feedback form for each segment of course that gathers asks the participant about the quality of the training and the impact it may have on their practice.

⁴ Program Information and image source: <https://www.diversityscience.org/>

Content:

- ◇ **Part 1: Laying the Groundwork** focuses on the experiences of Melissa (a fictional narrative based on lived experiences of Black mothers and birthing people in California) and her experience during childbirth. This segment also provides the perspectives on how racist stereotypes and historical oppression may impact perinatal care.
- ◇ **Part 2: Racism not Race** focuses on how racism in all of its forms impacts the care given to Black patients and strategies that work with our brains to interrupt racism in perinatal care.
- ◇ **Part 3: Taking Action** focuses on reproductive justice and patient centered care as two pillars of interrupting inequities in perinatal care. The training provides two strategies: 1) perspective taking and 2) partnership building.

Number of Accounts: The first module was released in the Fall of 2020, the second in early March 2021, and the third was released April 15, 2021. According to an interview with Diversity Science, director of External Engagement, Emily Ruff:

The registration data as of 4/1/21 included:

# of Registrants⁵ from CA	# of participants⁶ from CA	Perinatal patients per year⁷ represented by CA-based registrations
250+	190,000+	250,000+

⁵ Accounts range from individuals, small orgs with less than ten participants, up to large health systems registering for 75,000 participants

⁶ As reported by registrant of the account

⁷ As reported by registrant of the account

OFFICE OF MINORITY HEALTH:

Overview: OMH launched a new, free and accredited e-learning program: *Culturally and Linguistically Appropriate Services (CLAS) in Maternal Health Care*. The program, available via OMH's Think Cultural Health website, is designed to develop maternal health care providers' knowledge and skills related to culturally and linguistically appropriate services (CLAS). It is unclear if it meets the specific requirements of SB-464; it was launched on November 17, 2020, and expires December 31, 2021.

The content was designed by Office of Minority Health staff in partnership with General Dynamics Information Technology (an IT firm), overseen by an advisory work group including Dr. Joia Crear-Perry of NBEC and Dr. Monica McLemore of UCSF School of Nursing.⁸

Length: Two hours

Cost: Free, can be attributed to up to two credits of continued medical education

Format: Online, e-learning platform

Evaluation: N/A



Content: This course is designed for providers and students seeking knowledge and skills related to cultural competency, cultural humility, person-centered care, and combating implicit bias across the continuum of maternal health care.

- ◇ **In Module 1, An introduction to CLAS** in maternal health care, participants examine the role of CLAS in improving quality and eliminating disparities in maternal health care.
- ◇ **In Module 2, Self-awareness**, participants are asked to name their beliefs and values, as well as privilege, power, bias, and stereotypes.
- ◇ **In Module 3, Awareness of a patient's cultural identity**, participants learn how and why to get to know a patient's cultural identity.

⁸Program Information and image Source: <https://thinkculturalhealth.hhs.gov/education/maternal-health-care>

- ◇ **In Module 4, Providing CLAS in maternal health care**, participants explore ways to deliver respectful, compassionate, high quality care that responds to patients' experiences, values, beliefs, and preferences.

Source: <https://thinkculturalhealth.hhs.gov/maternal-health-care/>

Number of Accounts: As of April 14th, 2021 they have had 192 registrants in California (about ten percent of their national registrants). Of those registrants, about thirty percent have completed training.

Of the 192 California registrants, the majority were located in LA, Long Beach, Sacramento, San Diego, and San Jose. Most California registrants were nurses and physicians, though many administrators and public health officials signed up as well. Many registrants who have completed the course have opted to receive continuing medical education credits, nursing continuing education credits, or a statement of participation.

Table 3: OMH Registrants as of 4/14/21, Top Cities

Los Angeles	Long beach	Sacramento	San Diego	San Jose
10	7	7	7	6

Table 4: OMH Registrants as of 4/14/21, Top Professions

Nurse	Physician	Administration	Public Health Official	Other
49 (~36%)	27 (20%)	16 (~12%)	15 (~11%)	28 (~21%)

Table 5: OMH Registrants as of 4/14/21, Top Workplaces

Government	Hospital	Clinic	CBO	Other
39 (~25%)	34 (~22%)	30 (~19%)	25 (~16%)	26 (~17%)

HEALTH RESOURCES IN ACTION (HRIA):

Overview: This Boston-based public health consultancy company was contracted by San Diego County to create a SB-464 compliant training for partner hospitals. As of March 1, 2021 HRIA was in the final stages of creating the training so the specifics of the content, format, and evaluative components had not yet been released.

Length/Format/Content: TBD

Cost: The public contract between San Diego county and HRIA was for \$245,000 over two years beginning in 2021.

Evaluation: TBD

Number of Accounts: Intended to provide training for all employees at 100 provider sites in San Diego county, as per contract with the county.

NON-EXHAUSTIVE LIST OF OTHER ORGANIZATIONS

These are organizations that hospitals have cited working with to implement birth or racial equity training. Some may offer SB-464 training, while most offer supplementary anti-racist training; further inquiry is necessary regarding their SB-464 compliant offerings.

- ◇ **National Birth Equity Collective**, founded by Dr. Joia Crear Perry
- ◇ **CMQCC- Birth Equity Tool Kits**
- ◇ **Cherished Futures For Black Moms and Babies** (LA)
- ◇ **iDream for Racial Health Equity**, Project Director, Wenonah Valentine (LA)
- ◇ **SisterSong**: Community Doula Network advancing birth equity (San Francisco)
- ◇ **Poverty Scholars at Poor Magazine** (based in the Bay Area)
- ◇ **ENACT** Inclusive Leadership Development (Bay Area)
- ◇ **Diversity Uplifts** with Dr. Sayida Peprah

See [Appendix III](#) for Table summarizing April snapshot of registration data across these modules.

OVERVIEW OF SURVEY

This section will provide an overview of the forty-two question digital survey disseminated to hospital-based providers.

DISSEMINATION AND RESPONSE RATE:

Hospital staff members were given the opportunity to respond anonymously in order to encourage participation, though in many cases respondents were willing to identify their hospital. Of twenty-six recipients who opened the survey link, fourteen participants responded indicating an approximate fifty-four percent response rate. However, the survey was disseminated by email to far more than twenty-six people using a snowball sampling method through various networks (primarily CMQCC birth equity partner hospitals, PEI county coordinators, and Cherished Futures for Black Moms and Babies in LA), making an overall response rate difficult to approximate. The survey response rate was low, likely because of competing constraints on hospital staff members' time as well as general reticence to offer up information about this sensitive topic that may bring hospitals under further scrutiny.

THE SURVEY RECEIVED FOURTEEN RESPONSES THAT REPRESENT TWELVE DISCRETE HOSPITALS ACROSS FOUR COUNTIES.

The greatest number of responses came from Los Angeles County as explained in Table 6. Table 7 shows the type of healthcare organization; the majority of responses were a non-profit hospital or healthcare organization. For hospitals who submitted the survey with the name of their healthcare organization, they may be referenced by name in the emerging themes discussion below as per the consent agreements of the survey. Individual respondents, while answering on behalf of their department or organization, held a range of positions mostly as a nurse manager, department chair, or director within their respective departments.

Table 6: Survey Respondents by county

Los Angeles	Alameda	San Bernardino	San Francisco	Declined to Respond
5	2	2	1	2

Table 7: Survey Respondents by Hospital Type

	Public	Non-Profit	For-Profit
Respondents	3 (25%)	8 (67%)	1 (8%)
All US Community Hospitals⁹	19%	54%	24%

MAIN SURVEY FINDINGS

- *Half of respondents worked at a hospital that had implemented SB-464 training; Half responded that their hospital had not yet implemented SB-464 compliant training.*
- *Of respondents who worked at hospitals who implemented training, fifty percent used the Diversity Science modules- expecting the third and final module to be released mid-April, 2021.*

Table 8: Who developed training for those who implemented?

Diversity Science	In-House (developed by employer/hospital)	In-House (collaborating with community partners)
3	2	1

- *Of respondents who had implemented training, the majority said that most or all of their staff had participated in training.*
- *About a third of all respondents reported that their department would require physicians with admitting privileges to complete the SB-464 compliant training.*
- *Many respondents (6) reported having already or planning to include patients in the process of designing, implementing or evaluating training.*

⁹ Source: AHA Fast Facts on US Hospitals, 2021: <https://www.aha.org/infographics/2020-07-24-fast-facts-infographics>

- *Few respondents (3) reported having already or planning to consult with a community-based reproductive justice or birth equity organization for designing, implementing, or evaluating training.*
- *All respondents reported that their organization clearly communicates to patients about the process for reporting a negative experience during birth or perinatal care.*
- *All respondents reported that their organization follows up with patients about their complaints if they report a negative experience. However, only one respondent said that community members or patients were involved in the accountability process around complaints.*

DISCUSSION OF SURVEY

Given the low response rate and sampling methods, these survey results cannot be taken as generalizable across California hospitals and healthcare organizations. However, they shed light on how some hospitals are understanding the bill requirements, and broad areas for improvement around accountability to patients and community partners. They also indicate that many hospitals are implementing Diversity Science training or an In-house training; these findings should prompt further research into evaluating the efficacy of those particular modules.

ONE OF THE KEY TAKE-AWAYS FROM THIS SURVEY IS THE CURRENT WINDOW OF OPPORTUNITY TO INFLUENCE HOSPITAL IMPLEMENTATION.

Many hospitals have not yet or are in the process of implementing their SB-464 and related training. Advocates and stakeholders should seize this opportunity to advocate for types of training implementation and evaluation they hope to see.

The following section can provide recommendations for influencing hospital training implementation. The qualitative data gleaned from asking hospitals to describe major *barriers to implementation* and successful *facilitators* for anti-racist workforce capacity building will build on the interview findings in the following discussion of emerging promising practices and barriers.

KEY FINDINGS: FACILIATORS & BARRIERS

COMMON FACILITATORS FOR IMPLEMENTATION

This section will provide a discussion of facilitators for implementing SB-464 compliant training, drawing on emerging themes from thirty-three interviews and fourteen survey responses.

- 1. Integration*
- 2. Evaluation*
- 3. Listen to and Follow Black Leadership*
- 4. Support BIPOC Birthworkers*
- 5. Staff Champion*
- 6. Transparency*
- 7. Funding*

COMMON BARRIERS TO IMPLEMENTATION

Organizational & Cultural barriers to Anti-Racist Workforce Capacity Building:

- 1. Slow Release of Modules*
- 1. Constraints on Human Capacity*
- 2. Lack of Organizational Awareness of Buy-in*
- 3. Healthcare System: Fractured & Profit-driven*
- 4. Traditional Medical Education: Not Anti-Oppressive or Patient-Centered*

Barriers to SB-464 Implementation due to Bill Language:

- 1. Lack of Funding*
- 2. No Guidance for HMOs*
- 3. Lack of Clarity around Vendor or Facilitation*
- 4. Lack of Enforcement or Incentive Measures*

INTEGRATION & GOING BEYOND SB-464 REQUIREMENTS:

Integration is not just implementing SB-464 compliant training that "checks a box". Integration requires an organization-wide commitment to anti-racism and broader practice. It means shifting culture and embedding equity into the fabric of an organization through opportunities to advance anti-racist practice and dialogue.

PLUG INTO A LOCAL CAPACITY-BUILDING NETWORK.

Capacity-building networks working with hospitals provide anti-racist workforce development beyond implicit bias training. I interviewed representatives working for the state- and county-level Perinatal Equity Initiative, Cherished Futures for Black Moms and Babies, and Dr. Karen Scott who has developed the PREM-OB tool and pursuant training.

- ◇ **PERINATAL EQUITY INITIATIVE (PEI) COUNTIES** have been integrating birth equity work into public health programs for Black mothers and birthing people since 2018. These counties receive funding under the state Black Infant Health program and state support for capacity-building and program implementation. Under BIH funding, PEI provides funding to eleven counties across California, identified by the state program according to their analysis of need. PEI counties are required to have a community advisory board and public awareness campaign, as well as pick one to two focused strategies. Of the eleven PEI counties, five (Alameda, LA, San Bernardino, San Francisco, San Diego) have chosen to focus on innovation as a strategy which may encompass Implicit Bias training. To evaluate effectiveness of the implicit bias training, some PEI counties are using a results-based accountability framework.

"It's not just about the training, it's about what happens 'after', the follow-up"

- Curley Palmer, Program Coordinator, MCAH- Perinatal Equity Initiative, Riverside County

- **CHERISHED FUTURES FOR BLACK MOMS AND BABIES** is a multi-sector, collaborative effort to reduce infant mortality and improve maternal patient experiences and safety for Black moms and babies in South Los Angeles and the Antelope Valley (Cherished Futures website). This joint initiative between the Public Health Alliance of southern California and the Hospital Association of California is also aligned with the Los Angeles County African American Infant and Maternal Mortality (AAIMM) initiative. Part of the work includes a two-year collaborative with five pilot

hospitals to adopt culturally relevant clinical and organizational practices to better serve Black mothers and birthing patients. The first year is capacity-building with hospital staff that involves identifying root causes, learning about the roots of historical racism and anti-Blackness in obstetrics, as well as grounding in local and department data. The first year concludes with designing implementation plans. Cherished Futures then supports the hospitals implementing those strategies and facilitates feedback and accountability from a Black women-led community advisory board. In an interview with Dana Sherrod, Project Lead, and Asaiah Harville, Birth Equity Coordinator, they shared that this program is about building a hospital-community partnership that is authentic, and co-created between hospitals, Black-led organizations, and Black birthing families. Because this two-year program is not explicitly dealing with implicit bias and may not meet the requirements of SB-464, Cherished Futures is encouraging partner hospitals to seek out implementing a module that works for their team, followed by deeper experiential training.



Photo provided by Cherished Futures for Black Moms and Babies from January 2020 Launch, before statewide Safer-At-Home Orders

- ◇ **DR. KAREN SCOTT & THE PREM-OB TOOL:** Building off the PREM-OB scale (see details on this instrument in Evaluation), Dr. Scott will be launching a three-year program for partner hospitals in January 2022. In an interview with Dr. Scott, she described how this training is not intended to comply with SB-464 because it focuses on obstetric racism not just implicit bias; “this is going to the next level”. It will span hospital policies, provider behaviors and practices, and organizational processes in what Dr. Scott describes as: “a 360-degree cultural shift”. The program will be centered on human-centered design and community-informed practice in partnership Black

women-led organizations and community members. Interested hospitals can contact Dr. Scott through her website for the SACRED birth study.

PROVIDE TOOLS AND OTHER TRAINING BEYOND IMPLICIT BIAS.

In interviews and surveying providers, people provided examples of other thematic trainings that perinatal departments have been implementing across the state. For example, Zuckerberg San Francisco General Hospital funded and implemented a birth equity training with World Trust and National Birth Equity Collaborative (NBEC).

Other training topics that have been implemented include:

- ◇ **How to address microaggressions**
- ◇ **How to de-escalate without calling the police/security** with the Poverty Scholars at POOR Magazine, a bay-area organization.
- ◇ **How to repair relationships and be accountable** when a family has experienced racism harm, led by SisterWeb a community-based doula network serving San Francisco's Black, Brown, and Pacific Islander birthing families.
- ◇ **Cultural Humility Training** led by Wenonah Valentine and her LA-based organization, iDream of Racial Health Equity. iDream and Ms. Valentine is currently working with California Hospital and Cedars Sinai, as well as advising Cherished Futures.

TRAINING IS FOR THE WHOLE CLINICAL TEAM.

Multiple interviewees stressed the importance of training all clinicians and staff members regardless of role or professional status. For example, San Diego county PEI contracted HRIA to train entire "Provider sites", indicating coverage of everyone from the front desk staff to each healthcare provider that touches a patient.

KEEP THE LEARNING GOING THROUGH SMALL LEARNING COMMUNITIES AND DEDICATED WORKING GROUPS.

Many interviewees and survey respondents referenced establishing a dedicated working group or committee to implement a broader anti-racist strategy. One survey respondent reported having established a department anti-racism committee. Another interviewee referenced the establishment of a Perinatal Pediatric Equity Task Force. Multiple interviewees and one survey respondent mentioned incorporating equity factors or conversations about race, racism, and respectful care into Grand Rounds. One hospital department even incorporates separate versions of rounds called “Equity Rounds”. Another hospital department described applying bias interruption and an anti-racist lens to their “daily huddle” for nursing staff.

Another version of a small learning community can be in the form of ongoing racial affinity groups. For example, San Francisco Department of Public Health established a white co-conspirators working group for public health department and affiliated clinicians who identify as white to do ongoing anti-racist work. They began by working through the text and reflective prompts in “***Me and White Supremacy***” by Laayla F. Saad.

“One training is never enough” - Shivaun Nestor, Director of Family Planning, San Francisco Department of Public Health

EVALUATION

This involves looking at your local or departmental data disaggregated by race/ethnicity, and other important indicators that may elicit social bias such as socioeconomic status, insurance status, etc. It means looking beyond biomedical data and quantifiable accounts, to qualitative data and patient-reported experiences.

Traditionally, evaluating health interventions has meant looking at pre/post health outcomes, disaggregated by race/ethnicity to shed light on disparities in care through biomedical outcomes. For example, departments could examine their own data for maternal and infant mortality and morbidity by race/ethnicity. However, multiple interviewees suggested that departments can also examine their own behaviors, disaggregating rates of diagnoses and pursuant treatment plans by race/ethnicity. For example, one interviewee suggested looking at how often low-dose aspirin was administered to prevent or delay the onset of preeclampsia for eligible patients.

"We need to disaggregate our own behavior by race rather than looking at the behavior of the patient. And we need to look for those disparities with rigor" - Dr. Ayanna Bennett, MD, Director of Health Equity SFDPH

EVALUATE DATA BEYOND BIOMEDICAL OUTCOMES.

Informants and survey respondents suggested the critical importance of evaluating qualitative markers of performance and quality of care, especially when trying to understand the patient experience beyond a birthing outcome. One interviewee suggested looking at data that captures patient interactions with security by race/ethnicity. Another suggested looking at survey responses with regard to the experience of the patient care team; not only patients but family members and supporting friends can also experience racism during their time in a clinical setting.

USE A TOOL TO UNDERSTAND PATIENT-REPORTED EXPERIENCE BEYOND CLINICAL OUTCOMES.

Two survey respondents reported that their department is in the process of implementing a PREM (“patient-reported experience measure”). Some have implemented a PREM scale developed by the CMQCC birth equity collaborative; another hospital is working with Dr. Karen Scott and the SACRED Birth Study to implement the PREM-OB scale.

PREM-OB Scale: Dr. Karen Scott, Associate Professor, OB/GYN Hospitalist, and Applied Epidemiologist at UCSF has developed- the only of its kind: PREM-OB (patient-reported experience measure of obstetric racism).

This is an instrument designed by, for, and with Black mothers and birthing people to measure the impact of the quality of care on patient experiences when they seek help or healthcare for childbirth. The measure captures patients’ experiences of obstetric racism through their own feelings, words, and experiences across patient-identified quality domains. Drawing on the SACRED birth study, Dr. Scott and her research team have created this validated tool, so that hospitals can create a benchmark for how they are

“If we only measure quality and safety through clinical or pathologic outcomes, or the absence of pathology, we really miss that even with a ‘good outcome’ obstetric racism is still happening in ways that undermine people’s autonomy, that degrades their value and worth as a human being.”

- Dr. Karen Scott; Bathija, P (Host). (2021, April 15)

PATIENT FEEDBACK MUST BE ACCESSIBLE AND CONNECTED TO AN ACCOUNTABILITY PROCESS.

Part of the SB-464 mandate requires hospitals to clearly communicate to patients about how to report discrimination during their treatment. All survey respondents answered “Yes” to the question, “Does your organization clearly communicate to patients about the process for reporting a negative experience during birth or perinatal care”. When asked to provide more details, one survey respondent reported that their department has a dedicated patient experience representative, an ethics hotline for reporting, and comment cards that patients can fill out. Another survey respondent said their department has clearly posted signs about how to report racism.

Key informants spoke about the need to make collecting patient-experience feedback safe and invited, including being intentional about the types of questions, the format, language accessibility, and the timing of when you solicit patient feedback.

It is also important that patient-reported experience be tied to an actionable accountability system, so that those sharing negative experiences feel that any harm will be addressed. All survey respondents replied “Yes”, when asked: “Does your organization follow-up with patients about their complaints if they reported a negative experience?” When asked for more details, most respondents provided details of an in-person or telephone follow-up with patients. The follow-up was usually undertaken by a patient relations specialist. While this represents promising attempts to engage patient feedback, it does not necessarily reflect the usability or safety of these feedback channels, as this was reported by hospitals not patients.

RECOGNIZE THAT DATA CAN REPRESENT REAL HARM.

When speaking about quantifiable disparities or direct patient-reported experience, it is essential to understand that the data may represent deep harm to individuals and their families. One interviewee suggested conceptualizing disparities as not just a statistically significant difference in data points between Black and white patients, but rather about setting a new threshold of zero tolerance for obstetric racism.

“We aren’t looking for statistical significance. It’s about ‘one is too many’. I want to get to zero, so if that’s the bar then anecdotal data from the community is where we need to look.”

-Ana Delgado, Assistant Director, Family Birth Center at Zuckerberg San Francisco General Hospital

LISTEN TO AND FOLLOW BLACK LEADERSHIP

Hospital departments and clinical settings need to work with community members and Black-led community-based organizations in authentic partnerships that disrupt harmful power dynamics and racism in traditional philanthropic partnerships.

LISTEN AUTHENTICALLY.

Many interviewees and respondents mentioned having community-advisory boards or patient advisors in their department. However, some interviewees spoke about the harm that can occur if a department or public health agency conducts a town hall, listening sessions, or survey without connecting that engagement with meaningful input and action.

County PEI programs have a community advisory board. The CAB in Riverside county have emphasized the importance of choosing a vendor of implicit bias training that has ties to the local Black/African-American community, which according to the county PEI coordinator, has meaningfully informed who they decided chose for training.

Some hospitals are conducting their own forms of patient engagement in the clinical setting. For example, one hospital which operates birthing centers in LA and Orange County, has established “Commit to Sit” sessions in which nurses are required at least once a day to sit by a patient and ask questions about their aspirations, fears, and priorities for their birth. The Clinical Operations Director for this department described it as a “sacred moment”.

CONTRACT BLACK-LED CBOS FOR TRAINING AND COMMUNITY ENGAGEMENT.



For hospitals who have yet to implement an SB-464 training or who are considering how to implement broader anti-racist strategies, there is a clear call to prioritize consulting, contracting, and working with local Black-led birth equity organizations.

"CITE BLACK WOMEN. PAY BLACK WOMEN."

***-DANA SHERROD, PROJECT LEAD FOR
CHERISHED FUTURES FOR BLACK MOMS AND
BABIES***

Another interviewee expressed concern that individuals and groups who have been doing birth equity work in their own communities are not being consulted now that a state-wide bill has been passed that directly relates to their work. This is leading to SB-464 training contracts going to out-of-state, external groups who do not necessarily reflect the communities who are most impacted by the issue on a local level. Another interviewee said that when it comes to measuring and evaluating local data, Black patients and Black-led organizations need to be a part of owning and analyzing the data that speaks to the experiences of their own community.

"The folks that should be checked in with are the folks who have been doing this work, equity and policy work, reproductive justice work, engagement in the Black Infant Health programs, especially those who have experience [...] It is not enough to hire a few Black folks, it's not enough to just have a conversation with a couple of Black people."

- Adjoa Jones, MBA, Visionary and co-lead of L.A./South Bay African American Infant and Maternal Mortality Community Action Team (SLASB AAIMM CAT), LA Countywide AAIMM Initiative

Dr. Scott's concept of cultural rigor helps to illuminate this recommendation: "As a social movement, cultural rigor dismantles the lies and starves the delusions that Black women's scholarship, Black birth workforce, and Black tech lack the scientific rigor to align clinical, structural and social determinants of health, and design robust and reproducible measures and interventions." (Scott et al., 2020) Dr. Scott asserts that white-governed institutions cannot be the lead-strategizers of solutions to anti-Black racism in a clinical setting: "You have no answer that Black women don't already possess" (Scott et. al, 2020) Culture rigor requires funders and healthcare institutions to move from traditional modes of tokenism in community engagement toward meaningful partnerships that center Black leadership, accountability, and healing around harms that occur.

This applies to philanthropy too. Philanthropic funding often overlooks funding work done by and for the community that the work is purportedly serving. Anti-Black racism permeates decisions to fund, a process that Dr. Karen Scott refers to as

A FEW WORDS ABOUT CALIFORNIA MATERNAL QUALITY CARE COLLABORATIVE: BIRTH EQUITY COLLABORATIVE

CMQCC is one of the more well-funded maternal health care quality improvement organizations in California. Their relationship with hospitals across the state allows them to house what is regarded as one of the most comprehensive statewide maternal data centers, often cited for work on maternal health disparities. I am grateful for collaborators at CMQCC, especially Leslie Kowalewski, who out of expressed support for this project and SB-464 helped to disseminate the survey link to hospitals participating in CMQCC's Birth Equity Collaborative. This outreach furthered the scope of this project by facilitating access to hospital staff that may not have otherwise responded and provided valuable insight into how some hospitals are implementing SB-464. It is also worth noting that it led me to receive survey responses who cited working conducting birth equity work with CMQCC and using their PREM tool. I have reported those findings with fidelity.

Through the course of researching this report, I have learned about harm experienced by leading Black women researchers working in the white-dominant perinatal quality improvement space (Scott, K.A., 2021). I have also come to learn that the California Healthcare Foundation, who funded Diversity Science, pulled funding from CMQCC's Birth Equity Collaborative in 2019 (CHF 2019 statement) citing in a public statement: "indications that shared values were not being upheld". As I learned of these public statements, my own values compel me to be transparent about them in this report. Additionally, interviews with birth equity leaders unearthed a common theme calling for alignment with Black-led research and advocacy. Therefore, in order to uphold the values motivating this report, I believe there needs to be further transparency and an accountability process around CMQCC's Birth Equity Collaborative and how they see their role in the birth equity movement and hospital quality improvement.

philanthropic redlining: “Community harm then becomes the byproduct of philanthropic redlining, a discriminatory practice of in-equitable distribution of philanthropic funds combined with neglect of justice-centered Black-led institutions, fueled by discriminatory notions that Black-led institutions are ineffective, inferior, and fraudulent” (Scott et. al, 2020) Contemporary funding mechanisms and white supremacist norms entrenched in philanthropy may mean that even if a Black-led group is contracted, they are subjected to all manner of control, forced urgency to prove results, or ‘strings attached’ to their work.

SUPPORT BIPOC BIRTHWORKERS:

This indicates a priority for hospitals to hire and retain a diverse perinatal workforce, and work with existing networks of BIPOC birthworkers outside the formal hospital system.

As mentioned in figure xx (CAB criteria), multiple PTBi CAB members mentioned the importance of hiring BIPOC healthcare providers and working closely with BIPOC birthworkers outside of the formal hospital system, such as doulas, midwives, and healers.

“You want staff that represents the community, and they should feel safe within their own position to talk about their experience as an employee.”

-Asaiah Harville, Cherished Futures For Black Moms and Babies; Birth Equity Coordinator

One hospital representative, who cited having amongst the lowest birth equity disparity rates according to CMQCC’s ratings, attributed her department’s success to the fact that her staff represents the community they serve. To illustrate this point she said, “My nurses recognize their patients at the grocery store”.

BE OR SUPPORT A CLINICAL STAFF CHAMPION.

Multiple interviewees mentioned the importance of having one or multiple people on staff (an MD or chief nursing officer) who will repeatedly raise the issue of implicit bias and racial equity, and will engage in dialogue and ongoing meetings with other stakeholders.

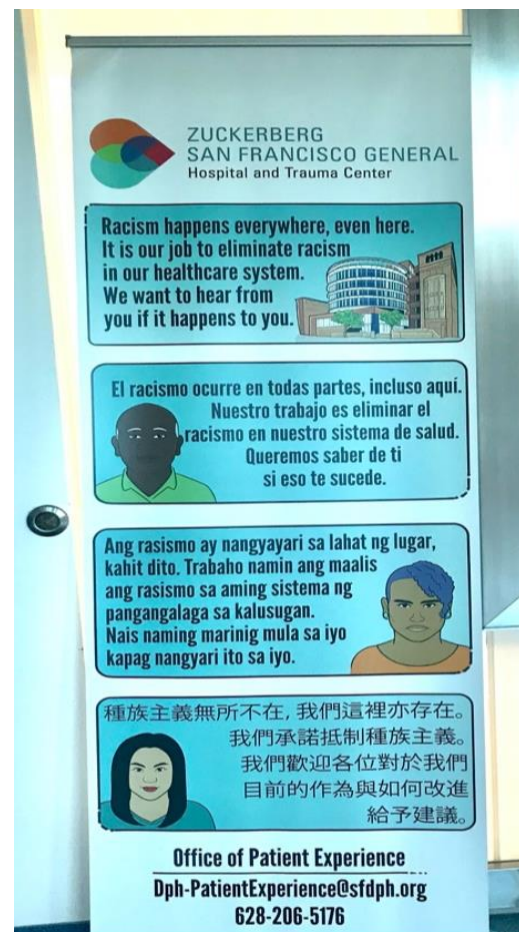
One public health official said that public health departments and CBOs are poised to support hospitals, but they need an inside “champion” who can act as a bridge into the clinical setting. Other CNMs spoke about their own role within the department as agents of change working to push the conversation on racial equity forward in their departments.

BE TRANSPARENT IN COMMUNICATION ABOUT RACISM.

Many interviewees talked about the importance of naming the problem transparently.

As one interviewee put it; “we need to be frank about racism as a root cause”. In the county where she works, Riverside county, the public health department decreed racism as a public health crisis, allowing their work to be centered in a root cause analysis. Public health department communication might also come in the form of a public awareness campaign, such as the San Diego County PEI public awareness campaign: Black Legacy Now.

In a clinical setting, one department uses visual cues to signal to patients that “Racism happens everywhere, even here.” The sign is hung in the department lobby and is translated into common languages spoken by patients. The same department also uses visual cues and posters in staff spaces to remind employees of affirming language and group agreements around respectful care and communication. Another survey respondent said they planned to work with their education department on creating materials for communicating to patients about their anti-racist commitment.



FUNDING

It is often said that budgets are where an organization makes their priorities visible. Healthcare organizations can demonstrate their commitment to ensuring that anti-racist capacity-building is ongoing and embedded in their organizational culture by dedicating annual budget items to related projects and offering grants to other groups to conduct training with their staff.

DEDICATE FUNDING TO ONGOING ANTI-RACIST CAPACITY-BUILDING.

While there exists a free SB-464 training option (Diversity Science funded by the California Healthcare Foundation) there is an opportunity for hospitals, payers, funders, and public departments to dedicate further funds to ongoing anti-racist training and related programs. For hospitals and payers operating in counties participating in PEI, there may be existing or available funding through the state initiative.

One interviewee reported that Anthem Health Equity will be paying for SB-464 training with March of Dimes within their partner hospitals in LA and the Bay Area. Anthem could not be reached to confirm, but this indicates a role that payers and associated foundations can play in funding work at their participating hospitals.

FUNDING IS AVAILABLE, BUT FURTHER OUTREACH OR TECHNICAL SUPPORT MAY BE NECESSARY.

When asked about funding availability, one interviewee who co-directs a committee for anti-racism and structural change in her division, said that grants exist in this realm but smaller organizations need the human capacity and to be made aware of the opportunities in order to apply. For example, her organization has had an RFP out for over six months for an organization to build a toolkit at the intersection of racial equity and birth equity, and has not received many applications.

PRIORITIZE FUNDING BLACK-LED COMMUNITY-BASED ORGANIZATIONS.

As mentioned above, multiple interviewees expressed frustration that despite Black women-led organizations being at the forefront of passing SB-464, Black-led organizations are being passed over for funding in the anti-racist workforce development space. Funders need to set priorities around contracting with Black-led organizations and supporting them with

actualizing community-led solutions to reproductive mortality and morbidity. Funders also need to have accountability structures to Black-led organizations, Black researchers and physicians, and community members (Scott et. al, 2020).

KEY FINDINGS: BARRIERS TO IMPLEMENTATION

This section will provide a discussion of barriers to implementing SB-464 compliant training, drawing on emerging themes from interviews and survey responses.

COMMON BARRIERS TO IMPLEMENTATION

Organizational & Cultural barriers to Anti-Racist Workforce Capacity Building:

1. Slow Release of Modules
2. Constraints on Human Capacity
3. Lack of Organizational Awareness of Buy-in
4. Healthcare System: Fractured & Profit-driven
5. Traditional Medical Education: Not Anti-Oppressive or Patient-Centered

Barriers to SB-464 Implementation due to Bill Language:

1. Lack of Funding
2. No Guidance for HMOs
3. Lack of Clarity around Vendor or Facilitation
4. Lack of Enforcement or Incentive Measures

This section will conclude with a comparison to similar bills with implicit bias training requirements, and an overview of potential enforcement measures that are commonly used in bills with regards to ensuring patient safety.

ORGANIZATIONAL & CULTURAL BARRIERS TO ANTI-RACIST CAPACITY BUILDING

SLOW RELEASE OF AVAILABLE MODULES

Multiple survey respondents cited waiting for materials to be released as a barrier to implementation. Due to the COVID-19 pandemic and generally slower rollout, many modules (OMH and Diversity Science) have been released recently during the Fall 2020 and Spring 2021. In the case of Diversity Science, the third and final module was released April 15th, and, according to an interview with Emily Ruff, External Engagement Director at DS, many larger healthcare organizations are waiting to see all the modules before deciding to implement staff-wide. We can expect to see a greater uptake of SB-464 training throughout the remainder of 2021, as the pre-made modules are fully available.

CONSTRAINTS ON HUMAN CAPACITY: BURNOUT & LACK OF WORKFORCE DIVERSITY

BURNOUT AND UNDERSTAFFING OF HEALTHCARE AND CBOS

It is well documented that frontline healthcare workers experience high levels of burnout and workplace stress. This was only exacerbated by the COVID-19 pandemic. Not only does constraints on human capacity and ongoing stress make implementing new training or programs difficult, but relevant to implicit bias, burnout and stress increase biased patterns, speech, and decision-making (Baumeister et. al, 2016). Additionally, hospital policies support biased behavior by understaffing, and creating a sense of urgency by encouraging rapid turnover of patients. Multiple interviewees cited that even if they've taken the training, the workplace policies and sense of urgency make implementing the techniques of interrupting bias challenging.

In an interview with Janice Mathurin, Director of Operations of West Fresno Health Care Coalition, she spoke about human capacity constraints on the part of community-based organizations who may have experience with establishing local community-led health interventions, but staffing constraints and competing priorities mean they cannot take more on. She spoke about how her organization could have potential aligned goals with SB-464 training, but they need to fund and hire another community organizing position first.

BLACK AND INDIGENOUS PROVIDERS, AND OTHER PEOPLE OF COLOR ARE NOT WELL REPRESENTED IN THE PERINATAL WORKFORCE.

One interviewee shared about how the white-dominant work environment creates a hostile environment towards incoming Black doctors; this is an explicit barrier to anti-racist organizational development.

"We scare [Black residents] away [...] If staff aren't treated well, how can patients be?"- Shivaun Nestor, Director of Family Planning, San Francisco Department of Public Health

Another interviewee noted that anti-racist training and departmental pressure to provide culturally congruent healthcare can over-burden BIPOC providers if there are few on staff. This interviewee talked about the over-burdening with responsibility for providing majority of culturally congruent care, or a pressure in dialogues to represent a certain perspective. An interviewee spoke about her experience facilitating structural competency training for practitioners, and as a facilitator, she noted that the lack of diversity creates challenges for facilitators to cultivate safe and generative racial affinity spaces and cross-racial dialogue in the workplace.

ORGANIZATIONAL AWARENESS OR BUY-IN:

Multiple interviewees referenced some kind of barrier around individual or organizational lack of awareness or an explicit pushback. This comes in many explicit forms (e.g. "that's not my job"); and other pernicious, less explicit forms like liberal exceptionalism, white fragility, and enlightenment hubris.

BELIEF THAT THIS IS OUTSIDE SCOPE OF PRACTICE

One interviewee cited co-workers believing that this kind of training is "not part of my job description." Another interviewee noted that, especially if a department does not have champion staff members, they may not even be aware that they need to implement SB464 training.

"I'm sure that our hospital would not be as far along as we are with SB464 compliance if I had not been involved with the bill from the beginning."

- Ana Delgado, Assistant Director, Family Birth Center at Zuckerberg San Francisco General Hospital

This lack of awareness may be more widespread. When asked why their organization had not implemented SB-464 training yet, one respondent replied "I was not aware of the bill or training requirement." While disappointing, the individual ignorance or pushback against integrating anti-racist capacity-building and implicit bias awareness into healthcare roles is unsurprising given how varying departmental prioritization of this kind of work can be. When asked "How often does your organization give perinatal healthcare professionals the opportunity to work on anti-racist personal and professional development?": Three respondents replied "never/not often", while the majority declined to respond. Three respondents replied "Sometimes/Often." Perhaps individuals would come to understand this as part of their job, if their department actively reinforced that idea by re-writing job descriptions, requiring ongoing training, and providing multiple ongoing opportunities to practice anti-racist capacity-building.

LIBERAL EXCEPTIONALISM & ENLIGHTENMENT HUBRIS:

One interviewee expressed a concern in her department in the form of “liberal exceptionalism”; she described this as co-workers believing that since they lived in a progressive region of California, they “did not have a race problem.” Multiple interviewees expressed concern that their coworkers or management would become complacent and not continue the conversation or look for other ways to incorporate anti-racist capacity building in the workplace.

WHITE FRAGILITY AND RACIAL TENSION BETWEEN CO-WORKERS:

Multiple interviewees cited white fragility, exhibited by white coworkers, as a barrier to implementing this work. This display of white-centering emotions in dialogue about race and racism can actively harm co-workers and participants of color, while propping up white dominance by keeping white folks’ reactions and emotions at the forefront. Another interviewee mentioned explicit tension in her workplace between some white and co-workers of color around the role of security and policing on the hospital campus. She suggested that the department needs training and dialogue around other aspects of systemic racism that are related to health of Black birthing families and de-escalation without involving the police.

Challenge Enlightenment Hubris

The interviewees were describing what Professor Juanita Capri Brown calls “**Enlightenment Hubris**”. Juanita Capri Brown, a lecturer at UC Berkeley and a Social Equity Consultant with a focus on racial equity and healing, broke this concept down further in an interview for this report.

As Professor Capri Brown describes, one of the pillars of white supremacist logic is the faulty good/bad binary in which one is either racist or not racist, either good or bad. Many have written about how the logic of binaries has been used by white-dominant culture to, as Professor Capri Brown, described “codify, control, and predict.” This kind of binary thinking leads people to a “**faulty on/off rationale [...] it tricks people into thinking that they are done**”. Rather, anti-racist capacity building is not a technical skill set that one can learn in one afternoon; it is an ongoing dynamic learning and reflective process.

When an organization conducts a one-time or limited anti-racist or implicit bias training and then begins to communicate both internally and externally that they have ‘completed’ anti-racist development, it is a form of racialized gaslighting for people of color who experience racialized harm while interacting with the organization. Professor Capri Brown gives language to the anxiety that interviewees were expressing about their organization or coworkers believing they were “done” and “good” by completing one training.

HEALTHCARE SYSTEM IS FRACTURED AND PROFIT-DRIVEN

Some interviewees spoke about their experience as public health advocates trying to reform a whole industry that is not centered on patient care. In the US healthcare industry, clinical settings are profit-driven leading to workplace policies that increase hurried interactions and emphasize following protocol over responding to emergent patient needs. This marks an inconsistency between the strategies of interrupting implicit bias and the “overarching goal of the US health-care system, which seeks to maximise revenues by scheduling providers to see many patients in a short period of time.” (Penner, 2014)

One interviewee noted that the continuum of care between healthcare and public assistance programs is not properly-oriented around patient experience and emergent patient needs, especially those brought about by living under racialized capitalism. While they may be empathetic, obstetric care providers may not be versed in how to provide support and resources around housing precarity, accessing public assistance programs, mental health crises, or other challenges that may impact a birthing patient and their birth outcomes. Another interviewee noted that the birth equity interventions that a perinatal clinician can exert control over feel overwhelming when compared to the way that systemic racism is baked into so many other aspects of life that affect patient health.

“Taken as a whole, impacting birth equity is overwhelming and exhausting and feels like we are trying to boil the ocean” -Clinical Operations Director for a Birthing Center in LA

TRADITIONAL MEDICAL EDUCATION IS NOT INHERENTLY ANTI-OPPRESSIVE OR PATIENT-CENTERED

Multiple interviewees who conduct racial equity and structural competency training, noted that traditional medical education is not inherently patient-centered or anti-racist. They expressed a need to move beyond just implicit bias training to employing cultural humility and structural competency. These types of training are not just building on existing medical education, but in many ways are working against an education training that centers symptomatic alleviation over human-centered practice.

USE OF ASSUMPTIVE OR DISEMPOWERING LANGUAGE

Multiple interviewees cited the frequent use of disempowering language that is commonly taught and used in healthcare. This language paints individual decisions that the patient uses as the negative driver of symptoms or pathology. They cited this as a challenge to the strategies of interrupting implicit bias. While interviewees did not cite explicit language or

alternatives, they spoke about common clinical frameworks and terminology that seem to blame parents for their health outcomes due to their bodyweight, insurance status, family structure or other observable demographic characteristics. This is reminiscent of Dr. Scott, Dr. Britton, and Dr. McLemore's work on interrupting the "Mother Blame Narrative" defined as holding pregnant women exclusively responsible for the ill health of children or poor reproductive health outcomes, while ignoring the circumstances, environments, and situations in which each woman seeks to maintain health, to become pregnant, and to safely give birth to children (Scott, K. A., Britton, L., & McLemore, M. R., 2019).

BARRIERS TO SB-464: GAPS IN BILL LANGUAGE

THE BILL DOES NOT INCLUDE ANY STATE FUNDING OR REIMBURSEMENT TO LOCAL AGENCIES: IT IS NOT CLEAR HOW TRAINING WOULD BE FUNDED.

Some existing trainings cost money (i.e. \$50 a “seat” for March of Dimes) while the Diversity Science module is free, after being funded by California HealthCare Foundation. If hospitals and clinics want to institute ongoing training beyond an implicit bias module, especially by contracting a local Black-led organization to ground their training in community partnership, they will need to ascertain funding.

There are some state allocated funds for Black infant and maternal health programs, mostly directing services to Black mothers and birthing families. Under the state Black Infant Health program, the Perinatal Equity Initiative provides state funding to eleven counties to create local solutions to racial health disparities in perinatal and maternal healthcare. Of the eleven PEI counties, five have chosen to focus on a strategy named “innovation”, though this is widely thought of as including implicit bias tools. Those five counties are Alameda, Los Angeles, San Bernardino, San Francisco, San Diego. One PEI county, San Diego, is using PEI funds specifically contracted to Health Resources in Action to implement SB-464 compliant training. The contract was for \$245,000 for two years.

In some cases, a payer can provide funding for their partner hospitals. For example, according to Mashariki Kudumu at March of Dimes, Anthem Health Equity is paying for March of Dimes training in Anthem partner hospitals in Los Angeles and the Bay Area.

AREA FOR FUTURE RESEARCH: What other birth equity funds are available at city and county levels, especially in counties that do not receive PEI funding?

IT IS UNCLEAR HOW HMOS CAN PLAY A ROLE WITHOUT GUIDANCE FROM CA-DHCS OR FROM NCQA (NATIONAL COMMITTEE FOR QUALITY ASSURANCE)

Currently not all HMOs are required to be under the NCQA, which would reflect the highest level of issued guidance for an HMO, but they soon will be according to an interview with Jessica Nila at San Joaquin HealthNet. Nila shared that in order for HMOs to understand what role they can play, the California Department of Health Care Services needs to publish an All-Plan Letter for HMOs. Further research can be done into the process for public comment around DHCS guidance or what kinds of guidance to include. For example, one requirement could be for MediCal to require proof of training across staff in order to offer bundled rates to healthcare organizations.

Regarding NCOA guidance, the NCOA currently publishes HEDIS measures around prenatal immunizations and prenatal and postpartum mental screenings.

AREA FOR FUTURE RESEARCH: Could NCOA publish a HEDIS measure around patient-centered care and/or respectful care?

WITHOUT A PRE-APPROVED LIST OF TRAINING VENDORS, IT IS UNCLEAR WHICH TRAINING HOSPITALS, HMOS, OR HEALTH DEPARTMENTS SHOULD IMPLEMENT.

Multiple interviewees brought up this gap in the bill, and named the importance for hospitals to prioritize partnering with local Black-led reproductive justice or health equity groups to implement training.

As noted, birth equity advocates in Los Angeles pointed out a tension arising when public health officials or hospital administrators overlook community-led organizations or community input when selecting a vendor of training. All too often funding for equity initiatives go to out-of-state organizations. For example, Anthem Health Equity is partnering with March of Dimes- a national organization- to utilize their training in partner hospitals in the Bay area and LA. Another example in southern California, San Diego county contracted HRIA- a Boston based organization- for \$245,000 over the course of two years to train one hundred provider sites throughout the county. While San Diego PEI has a Patient Advisory Board, there were no non-county employees on the review panel for vendor selection. This indicates a process point by which community input could have been prioritized in vendor selection. Other countries or health organizations that are conducting an RFP or RFQ process to select a vendor should consider incorporating the perspectives of a community advisory board or trusted community-based organization as they solicit and select a vendor for training.

AREA FOR FUTURE RESEARCH: Where do opportunities exist for public health departments and hospitals to meaningfully incorporate community, advocate, and patient perspective in selecting a vendor?

WITHOUT BILL GUIDANCE OR REGULATIONS AROUND ENFORCEMENT THERE IS NO INCENTIVE OR CONSEQUENCE FOR IMPLEMENTING TRAINING.

The California Department of Public Health (CDPH) sent out an All-Facilities Letter to all registered hospitals and clinics in January, 2020 which notifies hospitals of the law requiring them to implement training, however it explicitly states that this is “outside the purview of CDPH’s licensing and certification program. Other states (OR, MS, CO, IL, NJ) are in process of passing or have passed similar bills requiring implicit bias or racial equity training with medical

and perinatal healthcare providers. As those bills get drafted and passed, further research could be conducted to understand what enforcement measures those bills contain and how that could be translated to California guidance.

COMPARING TO SIMILAR BILLS:

In California, SB-464 came on the heels of a group of bills requiring implicit bias training of various professional sectors. Building off of AB-1195 (2005) which requires continued medical education for all California physicians in “cultural and linguistic competency”, **California AB-241 (2019)** requires content regarding implicit bias to be part of continued medical education for registered nurses, physician assistants, and physicians by 2022 in order to be compliant with their respective board licensures.

AB-242 (2019) requires the Judicial council to develop a 2-hour implicit bias training for all California court staff, and requires the State Bar to adopt regulations to require this as part of mandatory continuing legal education by 2023.

AB-243 (2019) amends the state penal code so that the commission is required to develop and disseminate implicit bias training for all police officers. Unlike SB-464, AB-243 included a reimbursement to local agencies and school districts should the commission determine an associated cost.

All of these other bills require professional licensing bodies to adopt regulations to include this training, unlike SB-464 which does not formally require any hospital licensing body to include this training requirement as a condition for licensure. While SB-464 has no state dollars attached, AB-243 goes further to increase state budgets for police training, a contentious decision even under the auspices of providing implicit bias training amidst nation-wide debates around state and local spending on policing and racist police violence towards Black communities and other communities of color.

FURTHER RESEARCH ON LEGAL ENFORCEMENT AND BILL GUIDANCE.

A team comprised of a UCSF researcher and medical-legal experts from the UCSF/UC Hastings Consortium on Law, Science, and Health Policy, are conducting a legal analysis of SB-464 in tandem with qualitative research with various stakeholder groups including self-identified Black/African-American birthing patients in Oakland and Fresno and perinatal healthcare providers. The intent of this project is to provide evidence-based recommendations for local and state SB-464 implementation. Advocates should look to this pursuant research in the coming year for an in-depth analysis of SB-464 and AB-241 implementation and enforcement, particularly grounded in perspectives of impacted stakeholders.

In advance, I have compiled a high-level list of potential enforcement measures that are commonly used in the hospital quality improvement and patient safety space. These are for consideration and should be further analyzed for political feasibility and efficacy:

ENFORCEMENT: HOSPITAL LEVEL

- ◇ **Proof of training for physician admitting privileges:** California law generally prohibits hospitals from employing physicians except for limited circumstances. As a result, hospitals and physicians contract and align themselves in a variety of ways other than direct employment. Hospitals could require SB-464 compliant training in their admitting privileges or contracting. This was an original comment on the bill, but was not included in the final legislation.

ENFORCEMENT: PATIENT LEVEL

- ◇ **Patient advocacy and/or a media strategy can apply pressure from consumers:** Examples of this could include: A digital tool for discerning quality of care for Black patients and patients of color (e.g. [Consumer Report on C-section rankings](#)) or an awareness campaign like San Diego County Black Legacy Now campaign.

ENFORCEMENT: STATE LEVEL

- ◇ **Establish a state-level advisory committee or governing body.** This could be established through a Governor Executive order. Patient Safety Advocate Carole Moss has proposed a connection.
- ◇ **Proof of training for hospital licensure:** This would require buy-in from joint commission and/or Dept. of Healthcare Services Licensing and Certification
- ◇ **Establish incentive funding for hospitals.** This could be a state-administered or a public-philanthropic partnership grant for implementing anti-racist workforce capacity-building programs.
- ◇ **Health insurance payers apply pressure or provide funding for training.** This would require an All-Plan letter from DHCS or national-level guidance from NCQA.
- ◇ **Fine hospitals who do not comply.** This would require a state body to audit hospitals and request proof of training for all providers.

CONCLUSION

This report has been written amidst the ongoing COVID-19 pandemic. This pandemic has especially impacted frontline healthcare workers and community organizers with their regards to engage in this research. This isn't to say that this work is not vitally urgent, but to acknowledge the difficulty and collective grief of the current moment. I believe the hospitals that did engage with this work were selectively biased towards those who are actively championing birth equity work. Further research should be conducted to reach hospitals, providers, and payers who are not actively part of the conversation around birth equity and obstetric racism.

SB-464 is very much still alive in legislature. As recently as February 2021, an amendment to the data collection component was passed (SB-494; Hurtado, 2021), and bill guidance is expected to be issued later this year. Stakeholders should track the upcoming MEND study conducted by Dr. Sarah Garrett at UCSF and UC Hastings Consortium medical-legal experts that will provide stakeholder research around SB-464 and AB-241 implementation and evaluation guidance at local and state levels. Additionally, there will be questions about the two-year training refresher requirement on the horizon that further research should address.

Stakeholders should also look toward other crucial pieces of legislature around Black maternal health and reproductive justice; the federal Black Maternal Health Momnibus¹⁰ (2021) and CA SB-65¹¹ (Skinner, 2021), a state-level Black maternal health bill which includes several strategies to reduce pregnancy-related and post-partum death rates for Black birthing patients and other families of color.

My hope for this report is that it will influence hospital and clinical decision-makers to inform their understanding and implementation of SB-464, by going beyond a one-time required training and pursuing anti-racist, respectful, perinatal care delivery that honors the experience of Black mothers and birthing people, and their families.

The California Momnibus Bill not only redefines success of what our goals should be as a state around maternal health, but it sends a clear message to all future and current mommas, babies and families that your health matters."

- Nourbese Flint, Executive Director of Black Women for Wellness Action Project, a co-sponsor of SB 65.

¹⁰ Find more information at: <https://blackmaternalhealthcaucus-underwood.house.gov/Momnibus>

¹¹ Find more information at: <https://wclp.org/joint-statement-stopping-californias-momnibus-bill-contradicts-calls-to-protect-black-indigenous-lives/>

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APPENDIX

APPENDIX I: KEY INFORMANTS & INTERVIEWEES

Adjoa Jones; MBA, Visionary and co-lead of L.A./South Bay African American Infant and Maternal Mortality Community Action Team (SLASB AAIMM CAT), LA Countywide AAIMM Initiative

Alexandra Montague; Health Policy Researcher at UCSF-UC Hastings Consortium

Ana Delgado; Assistant Director, Family Birth Center at Zuckerberg San Francisco General Hospital

Ana Gruver; Maternal, Paternal, Child, Adolescent Health Director, Department of Healthcare Services, County of Alameda

Andres Echeverri; Director Business Development and Strategic Accounts, Quality Interactions

Asaiah Harville; Birth Equity Coordinator for Cherished Futures For Black Moms and Babies, Former Lactation Consultant

Dr. Ayanna Bennett; MD, Director of Health Equity, San Francisco Department of Public Health

Becca Amirault; Midwife at UCSF, Expecting Justice Doula Champion Dyad

Bridgette Blebu; PhD, MPH, Postdoctoral Scholar, OB/GYN, Reproductive Sciences, School of Medicine, University of California, San Francisco

Boris Kalanj; Director of Programs, Hospital Quality Institute

Carole Moss; Patients' Rights Advocate, Founder of the Nile's Project

Christine Bride; MCH Coordinator, Department of Health and Human Services, County of San Diego

Curley Palmer; PEI Program Coordinator, Maternal, Child, Adolescent Health, County of Riverside

Dana Sherrod; Project Lead for Cherished Futures for Black Moms and Babies

Dr. Debbie Allen; ScD, Deputy Director of Maternal Health at Los Angeles Department of Public Health

Deena Mallareddy; CNM at Zuckerberg San Francisco General Hospital, Facilitator with Structural Competency Working Group

Diamond Lee; LADPH, MSW, Racial Equity Trainer, LA County African American Infant and Maternal Mortality Initiative

Diane Beck; RN, Clinical Operations Director for Labor & Delivery, Miller Children's and Women's Hospital Long Beach

Emily Ruff; Director of External Engagement, Diversity Science

Erica Rajabi; Vice President Women's Health at UCSF

Janice Mathurin; Director of Operations, West Fresno Health Care Coalition

Jessica Nila; Health Education Specialist, San Joaquin HealthPlan

Juanita Capri Brown; MPP, Societal Equity Consultant, Lecturer at Goldman School of Public Policy, UC Berkeley

Dr. Karen Scott; MD, PhD, Associate Professor, OB/GYN Hospitalist, and Applied Epidemiologist. Department of Obstetrics, Gynecology, & Reproductive Sciences and Humanities & Social Sciences, School of Medicine, University of California, San Francisco

Leticia Lopez; RN, MSN FNP, Nurse Manager Labor & Delivery, California Hospital, LA

Mariya Rabovsky-Herrera; San Joaquin Maternal and Child Health Coordinator, Department of Health and Human Services, County of San Joaquin

Mashariki Kudumu; Maternal and Infant Health Director, March of Dimes

Nordia Williams; State Perinatal Equity Initiative Coordinator

Dr. Patience Afulani; PhD, MD, MPH, Assistant Professor, Epidemiology & Biostatistics, School of Medicine, University of California, San Francisco

Dr. Sarah Garrett; PhD, Health Policy Fellow at UCSF, Institute for Health Policy Studies

Shelley McDonald Samm; Chief Nursing Manager at Sutter Solano

Shivaun Nestor; Director of Family Planning, San Francisco Department of Public Health

Tammy Turner; Perinatal Nurse Manager, MLK-LA

Terri Nikoletich; RN, MSN, MPH, CNS, Program Director of Perinatal Education, & Lactation Support Service Miller Children's and Women's Hospital Long Beach

Wenonah Valentine; Racial Equity Trainer, Project Lead iDream for Racial Health Equity

APPENDIX II: ADAPTED INTERVIEW QUESTIONS

Key Research Questions for hospitals/Providers who work in perinatal setting (adjust for relative ability to make decisions regarding implementation)

Are you aware of SB-464?

What is your understanding of the scope and intent of SB-464?

Are you aware of your hospital implementing any SB-464 training?

If YES->

What training module or vendor are you using?

How many modules/hours?

How many providers have been trained? Remain to be trained?

What barriers to implementation exist?

What has made implementation successful?

How did you procure funding for training?

Who is responsible for implementing and collecting certification?

Were patients, community-based birth workers, or CBOs involved in the selection, design, or facilitation of training?

If NO->

Do you know the options for existing training?

What training modules or vendors are you aware of (if any?)

What is your capacity to implement training?

How many modules? Hours?

How many providers have been trained?

How many staff members need to be trained?

What barriers exist?

If you would describe the training as successful, what are some of the determinants of that success?

How do you plan to involve patients, community-based birth workers, or CBOs in the selection, design, or facilitation of training?

How will you measure the impact of implicit bias training on birthing outcomes and patient experience?

What data are you collecting?

What data would you need support collecting?

Are patients involved in the evaluation of the impact of training on patient experience?

When patients experience mistreatment or discrimination, what if any policies or procedures are in place for them to report on their experiences?

Are community members/patients involved in the accountability process?

How do you communicate back to a particular patient about a reported case/grievance and how it was handled?

How accessible is the communication around grievances/reported discrimination? (provide materials if poss.)

How does your organization give perinatal healthcare professionals the opportunity to work on personal development as it relates to the care of others? As it relates to racial identity and racial bias?

Key Research Questions for Vendors:

Can you describe the content and format of the training?

How many hospitals/licenses have you issued/sold to date?

Can you provide up to date registrant information by account type, location (zip code/county), number of employees, and type of employees (i.e. CNM, OB/GYN)

How much does the training cost?

How much did it cost to create?

Do you support hospitals in procuring funding?

How long does the training take to complete?

How will you measure/assess quality or impact of training on quality of care and patient experience?

Were community members or patients involved in the creation of the training?

Who is typically the main contact between hospital and vendor?

Are you collecting the recertification data?

Do you have any requirement or ability to report certification to state DPH regarding bill compliance?

Key Research questions for birth equity advocates and public health department program staff:

What is your understanding of the scope and intent of SB-464?

Do you know the options for existing training?

If yes, is the training that exists feasible for implementation?

What barriers exist?

If successful, what are the necessary conditions? Promising practices?

What are the necessary components of implicit bias and racial equity training in a perinatal healthcare setting?

How should the impact of the training be assessed?

Could your organization provide hospitals with support for any of the following: (Measuring impact/Data Collection, Implementing training, Bill guidance @ legislation (Dept. of Healthcare Services), Advocacy, Bringing in patient/community perspective in bill guidance, Other)?

APPENDIX III: EARLY APRIL SNAPSHOT OF SB-464 TRAINING REGISTRATION DATA

<p>Diversity Science¹²</p>	<ul style="list-style-type: none"> ◇ 250+ Registrations¹³ from CA ◇ 190,000+ individuals ◇ 3 survey respondents (others indicated plans to use DS but have not yet) ◇ Interviewees: Sutter, California Hospital, ZSFG
<p>March of Dimes</p>	<ul style="list-style-type: none"> ◇ Anthem Health Equity Partner Hospitals- LA/Bay Area ◇ E.g. MLK-LA ◇ 25-30 individual and 8 organizational accounts had been purchased in California¹⁴
<p>Health Resources in Action</p>	<ul style="list-style-type: none"> ◇ San Diego County PEI Partner Hospitals/"100 Provider sites"
<p>Office of Minority Health¹⁵</p>	<ul style="list-style-type: none"> ◇ 1 survey respondent ◇ 192 Registrants in California (10% of national registrants) ◇ Of California registrants, about 30% have completed training
<p>ENACT</p>	<ul style="list-style-type: none"> ◇ UCSF
<p>In-House</p>	<ul style="list-style-type: none"> ◇ 3 survey respondents

¹² As of self-reported registration data (4/2/21) shared by Diversity Science

¹³ Registrations represent one account which could be an employer of thousands of employees or an individual

¹⁴ As shared by Quality Interactions (2/21)

¹⁵ As of registration data (4/14/21) shared by OMH

	◇ Highland indicated plans to create training w/ Dr. Scott and Prem-OB tool
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