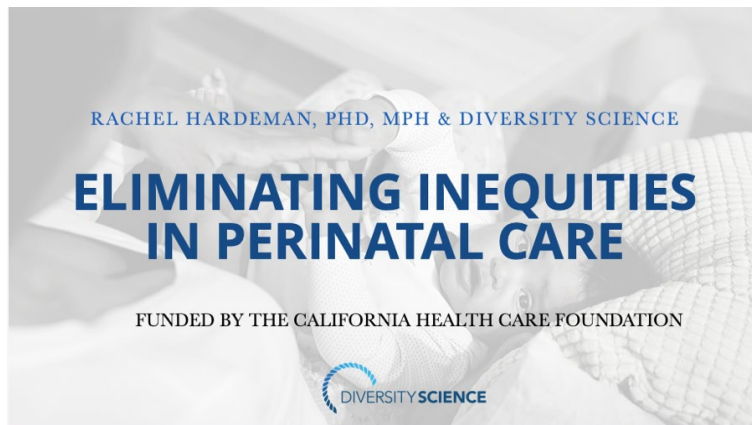


June 29, 2020

Dignity in Pregnancy and Childbirth eLearning Plan

Approach and Learning Objectives for Stakeholder Review

Presented by:



Project website: <http://equalperinatalcare.diversityscience.org/>

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Letter to Stakeholders

Dear Stakeholders,

We are delighted to provide you with this detailed document on our approach and our objectives for this important eLearning. Thank you for your ongoing participation and enthusiasm for this project. We appreciate your time and energy and look forward to receiving your feedback.

With gratitude,

Rachel Hardeman, PhD, & the Diversity Science Health Care Equity Team

Review Process

Stakeholder review and feedback is a critical component of this project. We invite you to:

- Review this document.
- Provide feedback, comments, and suggestions on our website – click [here](#).
- If you wish, give us permission to post your feedback. There will be a delay of one or two business days for content review and moderation.
- Review the feedback others have provided.

How to Provide Feedback

- We are collecting feedback on our website - click [here](#).
- After you navigate to that webpage, please provide your comments and suggestions in the text boxes.
- There are no limits on the length of feedback - write as much as you want.
- You can type directly into the text boxes, but we recommend writing up your feedback in a word processing program and then cut and pasting it into the text box(es).
- You may not want to answer all four of the questions - please give us feedback, suggestions and comments in any way that works best for you.
- At the bottom of the page, you will have an opportunity to let us know if you want your feedback posted publicly for others to see vs. prefer that they are only seen by Dr. Hardeman and the project team.

If you have any problems or need accommodations, please email us at equalcare@diversityscience.org

How to Use This Document

This document is organized into three major sections, two supporting appendices and a reference section:

- A) Background
- B) Our Approach
- C) Detailed Knowledge and Learning objectives
- D) Appendix One: Behavioral Learning Objectives and Resource
- E) Appendix Two: Crosswalk of Our Objectives with the Specifications in SB464
- F) References

Please review Section B (Our Approach) before providing feedback on the Knowledge and Learning Objectives.

A. Background

A.1 Project Purpose

This project is part of an initiative whose goal is to ensure that Black women and birthing people achieve their full potential for healthy and productive lives. The overall goal of the project is to empower perinatal care providers with the foundational knowledge, insights and skills they need to ensure that Black women and birthing people receive fully equitable patient-centered, respectful, high-quality care free of bias and discrimination.

A.2 Project Charge

The [California Health Care Foundation \(CHCF\)](#) funded Rachel Hardeman, PhD, MPH and Diversity Science to:

- 1) Develop an evidence-driven anti-racism e-Learning experiences for perinatal care providers that is fully responsive to the objectives of CA SB464,
- 2) Develop materials for health care organizations and internal change agents, and
- 3) Deliver this intervention, free of charge, to all California perinatal care providers and organizations.

A.3. The Problem

A.3.a. Racial Inequities in Maternal Morbidity and Mortality

In the US, Black women are twice as likely to experience a preterm birth (PTB), give birth to a low birth weight (LBW) infant, or experience the death of an infant before age 1 compared to white women.

Similarly, Black women in the US are 3-4 times more likely to die during or in the year following childbirth.

These profoundly disturbing inequities have endured for as long as data have been available. These outcomes persist through recent declines in the total infant mortality rate and despite efforts aimed at improving access to prenatal care and early childhood initiatives. They persist after controlling for socioeconomic status and education. Decades of medical and public health research have documented the magnitude and persistence of racial inequity in maternal and child health.

A.3.b. Racial Inequities in Perinatal Care

Racial inequities in *perinatal care* have been shown to contribute to the excess suffering, illness and death suffered by Black women and infants. Studies have found inequities in the use of prophylaxis, in the assessment processes, in the threshold of diagnostic suspicion, in the threshold for treatment, and in the use of procedures that increase patient risk. Black mothers' reports and research evidence point to major inequities in interpersonal quality of care, ranging from lower patient-centeredness for Black vs white women to outright bullying/abuse. Overall, a large proportion of maternal morbidity and mortality are preventable. In a study examining preventable maternal death, near miss, and severe morbidity, patient factors were cited in 13% to 20% of cases, system factors were cited in 33% to 47%, and *provider-related factors were cited for approximately 90% of cases in all 3 groups*. Empowering providers to reduce inequities in perinatal care is a crucial step towards elimination of the unnecessary and excessive suffering, illness, and death experienced by Black mothers.

A.4. The Need

There is major unmet need for effective interventions that empower perinatal care providers to prevent racial inequities in care and outcomes. Few health care personnel have received adequate training in structural racism, its impact on Black patients, and implications for equitable care. That results in a blind spot regarding the way the health care system has been shaped by and reinforces structural racism – a blind spot that hampers providers' ability to join with and provide the kind of quality care they want for their Black patients.

Providers have a direct and important role in reducing care inequities through providing equitable, compassionate, patient-centered care. They also have opportunities to protect or buffer their patients from the impact of structural racism of the delivery of health care. Thus, interventions that both empower perinatal care providers' with the ability to provide unbiased care and to help to buffer their patients from the detrimental effect of structural racism, have significant promise for reducing inequities in perinatal care and outcomes.

A.5. The Law

The passage of groundbreaking legislation, CA SB464, [the California Dignity in Pregnancy and Childbirth Act](#), provides an unparalleled opportunity to make state-wide change in Black women's perinatal care experiences and outcomes and thus significant progress towards reproductive health equity.

B. Our Approach

B.1. Evidence-Based

The development of the e-Learning Experience (LE) is fully responsive to cutting-edge [evidence](#) from a wide array of relevant disciplines. The evidence base can be placed in three broad categories of evidence: 1) evidence that drives [knowledge](#) and [behavioral learning objectives](#), 2) evidence that guides our approach for engaging providers in anti-racism and bias-prevention interventions and activities, and 3) evidence regarding best practices in using digital e-Learning modalities to promote adult learning.

Our approach is guided by evidence on the factors that help empower learners and enhance their ability to absorb and act on difficult or distressing material such as racism, by:

- (a) Creating a psychologically safe learning environment.
- (b) Promoting a growth and learning mindset to interracial interactions.
- (c) Elucidating the connection between intervention objectives and their own closely held values.
- (d) Providing learners with specific, feasible strategies for living their values, buffering their patients from structural racism, and providing equitable care.

B.2. Learner-Centered

Our approach respects perinatal care providers (learners) as active agents that bring their backgrounds, challenges, experiences and existing circumstances, knowledge and beliefs, sociocultural values and ideas that impact how they integrate new information and learn.

We keep in mind that:

- (a) Learners are most engaged when learning experiences are clearly relevant to things that matter to them.
- (b) Learners are most motivated when they feel like they are solving real problems and learning skills they can put to work immediately.
- (c) The more engaged healthcare professionals are in the learning process, the more they will retain and apply when they get back to work.

B.2.a. Meeting learners where they are

Training is most effective when it meets learners where they are.

Perinatal care providers are at various stages in their journey in understanding racism and racial inequities in care. Some may have had exposure to the concepts and may be predisposed toward or against learning more about it. In an ideal world with a great deal more time and resources, we would develop e-Learning Experiences that are tailored to reflect learners' existing knowledge, beliefs, and

attitudes. We hope to do this in the future. In this project, we are creating the most effective approach for the largest body of learners possible.

- (a) Many will need support for unlearning erroneous beliefs.
- (b) Almost all will benefit from accurate facts about the causes and remedies for racial inequities in care.
- (c) Many learners will have heard the statistics about Black maternal mortality and morbidity yet will not have a good understanding of what they can do to improve things.
- (d) Most health care providers have personal values that align with fairness, equity, and justice. This training is for them.

B.2.b. Motivated racism

- (a) A small percentage of health care personnel consciously and intentionally hold a racist world view. A few may be swayed by the evidence we provide in the LE. Others will be motivated to discount, undermine, and discredit this and other anti-racism initiatives.
- (b) A major challenge to progress towards equity is that even people who hold the idea of equality and justice close to their hearts are vulnerable to being influenced by motivated racists if they do not have access to a clear understanding of and facts documenting the causes of racial inequities. The goal of this training is to arm them with the information they need to protect themselves and their patients from motivated racism.
- (c) The uptake of new perspectives and facts create new professional norms which serve to keep outlier providers within bounds. This training may directly affect the behavior of motivated racists by setting new professional norms and by arming and inspiring anti-racist perinatal care providers to interrupt their impact on the organization and patients.

B.3. Best Practices

We teach learners to bravely walk in the worlds of their patients by promoting a growth and learning mindset that allows them space to practice new anti-racism skills and learn from mistakes. A growth and learning mindset promotes a commitment to lifelong learning

- (a) To engage learners, each learning experience will:
 - Demonstrate a clear connection between the learning objectives and their own closely held values
 - Tell a compelling story that ties powerfully to the topics in the learning experience.
 - Offer practical strategies to interrupt racism, taking learners through a series of activities and reflections that will give them in-session practice.
 - Engage learners in case study analyses and applications to reinforce learning

- Each section will bring in an historical example of racism, in order to connect present day conditions with past discrimination, exclusion, and marginalization.
- To create a commitment to specific action, learners will create “implementation intentions”, new behavioral orientations, to apply to the aspect of patient care they normally provide
- To support retention and commitment to change, their work in the exercises will be captured in a PDF they can download or print. The book will also have additional resources and materials. Learners can retake the learning experiences any time.

C. Detailed Knowledge and Learning Objectives

The eLearning experiences seek to promote knowledge, attitudes, and [behavior](#) shown to be effective at interrupting racial bias. We empower learners with clear, specific, and proven strategies for interrupting racial bias and institutional racism.

We organized the learning objectives by overarching learning goals rather than by the order they are addressed in the Learning experiences. **The order of the learning objectives below does not reflect the order of content as it will be presented in the e-Learning experiences.**

Objective 1: Empower providers by increasing their structural competency through a [deeper understanding of structural racism](#).

C.1.a. What is “structural competency”?

For healthcare professionals, structural competency is the ability to recognize and respond to the powerful social and institutional (upstream) conditions/ policies that impact or even determine health outcomes before and after a patient arrives to receive care (downstream). Structural competency and structural humility incorporate cultural humility.

C.1.b What is “structural racism”?

Structural racism is the “confluence of institutions, culture, history, ideology, and codified practices that generate and perpetuate inequity among racial and ethnic groups.”

C.1.c. How will understanding structural racism empower providers?

The vast majority of perinatal care providers deeply *want* to provide good care. However, when it comes to Black mothers and birthing people, many are hampered by a lack of crucial knowledge and skills. They have not been given the training they need to be fully empowered to provide high quality care.

Just as false information about the physiology of the human body can lead people to the wrong conclusions about the cause of signs and symptoms of disease, inaccurate information about the

forces that affect Black patients can lead providers to come to the wrong conclusions about the causes of their patients' illness, symptoms and behavior. Both scenarios prevent the provider from truly helping their patients. In addition, in order to provide quality care for their patients, providers need to understand the deep causes of their current health challenges. Lastly, providing high-quality care means to provide care that is responsive and fits into the reality of their patient's lives.

C.1.d Structural Competency & Racism Learning Objectives

The ultimate goal of structural competency training is to advance learner understanding of the structural factors frequently invisible within the clinical setting, that determine patients' health and illness.

Participants will be able to:

- (a) Describe the current evidence on racial inequities in perinatal care and outcomes
- (b) Tell a story illustrating the impact of structural racism on patient experience, from the patients' eyes.
- (c) Describe the evidence regarding the provider contribution to racial inequities in care
- (d) Describe the way inequities in health care parallel the evidence of inequities in other parts of society.

Participants will become curious about:

- (a) What caused these inequities.
- (b) What maintains inequities – why inequities persist

Participants will be able to:

- (a) Describe the legacy of slavery, historical and contemporary discriminatory policies, and cultural stereotypes
- (b) Define structural racism
- (c) Explain the major ways structural racism affect the lives of Black mothers, infants, and families
- (d) Describe major ways structural racism plays out in the healthcare system

Participants will gain insight into, and empathy for the way their Black patients' expectations and interactions with health care could be affected by:

- (a) Medical mistrust
- (b) Racial trauma
- (c) Experiences of discrimination

- (d) Stereotype threat

Participants will be able to:

- (a) Define a [color-blind philosophy](#)
- (b) Provide examples of the way a provider color-blind philosophy can undermine patient experience and provider-patient relationships
- (c) Describe 3 or more specific actions they can take to reduce the impact of Black patients' experiences of discrimination, racial trauma, stereotype threat, on the interaction (overlaps with bias-protective strategies)
- (d) Identify 2 or more common institutional policies and procedures that have differential impact on marginalized groups
- (e) Describe examples of institutional policies and procedures that reduce inequities.

Participants will:

- (a) Write down and commit to (develop implementation intentions) 3 specific, feasible examples of actions they **will** take to reduce the impact of structural racism on Black mothers and birthing people.

Objective 2: Empower providers with tools and practices to reduce their own bias in the clinical encounter with Black mothers and birthing people.

C.2.a. What is racial bias?

Racial bias is conscious and/or unconscious, intentional, and/or unintentional negative attitudes towards Black patients. Even when implicit (automatic or unconscious), negative attitudes towards Black patients have a consistent impact on the quality of care that Black patients receive. The focus of this training is how to mitigate the impact of bias, no matter its source or level of consciousness.

C.2.b. What is implicit racial bias?

Implicit racial bias is when a negative attitude or stereotype is applied to a Black patient automatically, and often unconsciously. This is “unthinking” racial bias caused by exposure to stereotypes and attitudes in the larger culture. Since most providers have a genuine conscious commitment to, and highly value, justice, and equity of care, implicit or automatic racial biases prevent providers from fully living their values.

While implicit racial bias is often unintentional, they are affected by individual needs and motives. They are more likely to influence our behavior towards others when we are tired, have negative feelings, feeling threatened, or need a self-esteem boost.

They are also affected by organizational factors and norms

Understanding the personal and organization conditions that exacerbate racial bias is key to effectively interrupting racial bias.

C.2.c. Providers are mostly committed to racial equity. How will learning to interrupt racial biases empower those providers?

Participants will have learned about and oppose the widespread and tragic inequities in perinatal care for Black mothers and birthing people. However, they may not understand that good intentions are not enough. There is a large body of research evidence that there is a disconnect between providers' genuine egalitarian desire to provide the best care to all their patients and their discriminatory patterns of care. Automatic (implicit) racial biases are one explanation for this disconnect.

Physicians, nurses, and other providers have been shown to hold negative implicit biases towards Black patients as well as other marginalized, stigmatized, and undervalued groups. These biases can affect every aspect of the clinical pathway. Furthermore, negative implicit biases have been shown to persist independently of, and even in contrast to, providers' genuine desire to be unbiased and their explicit (conscious) attitudes.

Implicit racial bias can influence providers to act and make decisions that are in direct opposition to their values, conscious opinions, and genuine desires to provide equitable and just care.

C.2.d. How are personal implicit racial biases connected to structural racism? Don't they just let people "off the hook"?

Implicit racial bias and structural racism reciprocally influence one another.

The automatic mental processes that make it more or less likely that a person will act on an implicit bias are common across all humans.

The specific *content* of these biases, and the degree to which their *influence is allowed to persist*, are rooted in historical and structural racism.

Understanding that implicit biases can affect us in ways that are abhorrent to us – that are not consistent with our values – but that there are specific actions we can take to interrupt those biases, *increases* accountability for taking action.

C.2.e. Interrupting Racial Bias Learning Objectives

The goal of racial bias training is to empower learners with evidence-based strategies for interrupting the impact of personal bias on quality of interactions and care for black patients.

Learners will be able to describe the current evidence on:

- (a) The contribution of provider bias to inequities in perinatal care

Learners will be able to provide a basic explanation for:

- (b) Why providers are affected by structural racism in the care they provide, even though that is not consistent with their true values and motives, including:
 - i. The two separate mental systems we use to think about and make sense of other people (dual processing).
 - 1. System 1 – source of implicit (automatic, unintended, often unconscious) attitudes and behavior.
 - 2. System 2 - source of explicit (conscious, deliberate, intentional) attitudes and behavior

Learners will be able to describe the implications for patient care created by:

- (a) The way that System 1 uses stored information (automatic biases and stereotypes) to:
 - ii. Rapidly shape what we expect from others
 - iii. Guide what we pay attention to - what we notice about patients
 - iv. Affect what we recall about patients (and communicate to others)
 - v. Guide how we interpret patients' behavior
 - vi. Create a rapid emotional response that influences our non-verbal behavior
- (b) The way implicit bias can create a negative feedback loop by...:
 - vii. ...affecting provider non-verbal behavior, which in turn affects
 - viii. ...patient experience and trust, which in turn affects
 - ix. ...patient non-verbal and verbal behavior, which, affects provider behavior

Learners will be able to describe:

- (a) The relationship between provider implicit bias and patient adherence

Participants will be able to identify the:

- (a) Individual factors and implicit motives that affect the likelihood that implicit racial bias will affect their interactions with and care for patient
- (b) Situational/environmental conditions that increase the likelihood that racial bias will affect patient care

Participants will be able to name:

- (a) The [individual strategies](#) that have been shown to work (and to not work) to prevent unintended racial biases from affecting patient care and experience.

Participants will describe specific ways they will incorporate [personal bias-prevention strategies](#) into their work with patients.

Participants will:

- (a) Write down specific plans ([develop implementation intentions](#).) for putting 3 or more specific, feasible, strategies into practice.

Objective 3: Empower providers through the integration of knowledge and skills needed to protect their patients from racism

Learners will gain insight into the way implicit, often unconscious racial bias, and structural racism reciprocally influence one another. Although implicit racial bias is often considered as an individual-level influence in health care, such biases can shape the culture and other structural elements of health care organizations by influencing shared perceptions of the “ideal patient” in ways that systematically disadvantage Black patients in the quality of care that they receive.

Participants will:

- Describe two or more ways structural racism reinforces implicit racial bias
- Describe two or more ways implicit racial biases maintain structural racism.

Participants will be able to:

- (a) Review perinatal care provider questions and statements made to Black mothers and birthing people
 - Identify those that reflect a hidden racially biased implicit framework (set of implicit assumptions and beliefs)
 - Identify those that reflect structural competency (including structural and cultural humility)
 - Review a patient case study (patient story) and identify the way interpersonal, cultural, institutional, and structural racism affected the patients’ experience and outcomes

Participants will:

- (a) Identify the overlap between reproductive justice, professional ethics, and their closely held values
- (b) Sort concepts that are part of the definition of reproductive justice into a Venn diagram with three circles: 1. Principles of Reproductive Justice, 2. Principles embedded in my

Professional Ethics, and 3. My Values, showing the overlap between the definition of reproductive justice, professional ethics, and their own closely held values.

- (c) Prepare an action plan to ensure their practice is aligned with the principles of reproductive justice, professional ethics, and their personal values.

Appendix One: Behavioral Objectives and Resource Handout

The Learning Experiences **targets individual behaviors that are learner-centered and** been shown to have the greatest potential to interrupt racial bias.

Since anti-racism interventions can have unexpected negative effects, our approach uses strategies that are shown to prevent potential unintended side effects such as inter-racial anxiety and reduced motivation (among whites) to interact with racial and ethnic minorities.

Check for double-standards

Check for double-standards. When we¹ are assessing a patient's symptoms and we feel ourselves doubting the severity of their symptoms, we can take a minute and imagine how we would feel if someone different presented with the same symptoms. For example, if a woman is reporting pain and we feel like she is overreacting, imagine a man reporting the same symptoms. Would you think he was overreacting? By checking for double standards like these, we can prevent our biases from causing us to unfairly judging someone else.

Assume positive intentions

Assuming positive intentions on behalf of patients. We all have our own standards, traditions, and norms as a lens through which we view and judge others' behavior. People from cultures different from your own, likely have different traditions and norms. Our minds tend to automatically see "different" as "bad," causing us to automatically assume others have negative intentions when they act in ways that are not in line with our cultural norms. However, if we consciously choose to assume people's behavior is well-intended, we will make less biased judgments and we will learn to see behaviors rooted in diverse cultural traditions as valid and acceptable.

Listen for and Interrupt/Replace Biased Narratives

Whether we are aware of it or not, we tell ourselves stories about other people. Our brains want to make sense of others behavior. As you have learned, structural racism and implicit bias can lead to "Mother Blame" explanations; implying that negative birth outcomes are unpreventable because black women are coming to pregnancy "older, sicker, and fatter." These blame narratives take time to unlearn. Listen for them in yourself and notice them in the way others talk about patients. Since you now know how harmful this is to patients, you recognize your responsibility to gently point out automatic assumptions and offer alternatives.

Evaluate your skepticism

People automatically want to avoid things that are distressing. When we combine this with our automatic tendency towards confirmation bias, that is, ignoring evidence when it doesn't fit with

what we believe, or want to believe, and we are at risk for ignoring the evidence of discrimination and forgetting about training like this one. We are motivated to look for “good” reasons to explain away unfairness – to explain why some people have more than others or why bad things happen to others. We automatically look for, and prefer, less distressing explanations for experiences than racism. While understandable, we now know that this can be harmful and that we have a responsibility to listen to our patients,

While critical thinking and skepticism can be good, many studies show we are biased in the way we evaluate evidence of discrimination or differential treatment. Our medical institutions will be more effective if we all do our best to make people feel safe to talk about their lived experiences – about the world that they walk in. When someone tells you about exclusion and discriminatory experiences, believe them until proven wrong. Catch yourself seeking alternate explanations. Don’t explain away their experiences. Instead try to say things like: “I believe you.” or “I understand why you feel that way. I might too if I were in your shoes and it had happened to me.”

Self-care and emotion shifting

Studies have found that how we feel can affect whether we live our values or not. Implicit biases are more likely to affect what we do when we are busy, tired, feeling anxious or stressed, or generally depleted for any reason. We are even more likely to automatically and unconsciously apply negative stereotypes when our morale is low – scientists think this happens to help us increase our own self-esteem. When we work long hours under stressful conditions (as is common in many health care settings) it makes it even likelier that implicit racial bias will affect their treatment of patients. Learning these bias reduction strategies now will help prepare anyone to manage the myriad stressors they encounter every day

One of the best things you can do to prevent unintended biases from affecting your behavior is to learn and consistently use mindfulness, stress reduction, and emotion-shifting strategies. These help our mental energy and help us feel good about ourselves. Some stress reduction strategies can be used anytime, take very little effort, and can be done in just a few minutes. You can practice exercises like deep abdominal breathing and progressive relaxation in between patients or while taking a quick break. These exercises not only help to prevent implicit biases from affecting our behavior but also have many benefits for health and the way we relate to others.

Build partnerships

The implicit thinking system (“System 1”) automatically divides people into ingroup and outgroup members based on what society tells us is an important distinction, such a race, gender, or age. However, there are other things about people that we can focus on to include them in our ingroup. Including someone as part of our ingroup is a powerful strategy to prevent negative implicit bias and makes it easier to build partnerships with them. There are a few simple ways to make a patient part of your in-group. Discover what you have in common. Remember that as humans, we have many more commonalities than differences. Take a moment to find what you have in common with a patient. Use inclusive language – words like we, us, and ours instead of I, you, or them, when discussing treatment options. Try to think of yourself and your patient as a team, working toward a common goal. For

example, in one study, when white doctors and black patients were reminded before their appointment that they were on the same team, the quality of the encounter increased substantially.

Aim for Structural Humility

We walk in different worlds. We cannot truly know what another person's world is like. Each of us can only be an expert in our own world and lived experience. We help patients when we emphasize collaboration rather than assuming we know best.

Practice perspective-taking

Many studies have found that taking a moment to try to see things from the other person's perspective or imagining yourself in their shoes helps prevent implicit bias. Perspective-taking is a skill that can be learned and will become second nature if you make a point of practicing it as often as you can – with family, friends, neighbors, coworkers, and patients.

Since we walk in different worlds, it's important to check the accuracy of how you imagine the perspective of others. For instance, you could say: "I am wondering how I might see it if I were looking through your eyes..." or "I was imagining being in your shoes, and it occurred to me that I would feel this way. Am I close?"

Buffer patients from racism by creating a safe and healing space

Make the implicit, explicit

Ask things like²:

- "I don't want to assume anything about your identity. How do you identify racially, ethnically culturally and what are your pronouns?"
- Many of my patient's experience racism in their health care. Are there any experiences you would like to share with me?"
- Say "It's my job to get you. You shouldn't have to work to get me. If I miss something important or say something that doesn't feel right, please know you can tell me immediately and I will thank you for it."

Use trauma-informed practices.

Trauma-informed care considers the pervasive nature of trauma and promotes environments of healing and recovery rather than practices and services that may inadvertently re-traumatize. This can mean many things:

- Explain why you are asking sensitive questions and how the information will be helpful in providing the best care possible.
- Explain why you need to perform a physical exam,

² Questions courtesy of Southern Jamaica Plain Health Center (Boston Massachusetts)

- Ask permission before touching
- Tell patients if they need us to stop at any time, they can say the word.

If someone refuses outright to have a certain exam or test respond with compassion and work with them, rather than attempting to force them or becoming annoyed.

Consider the environment

Audit the space for stereotypic images. Consider how you might change or add things to signal that this is a safe space. Consider pictures on the wall, pictures in patient education, and magazines in the waiting room.

Pay attention to your language

The words we use and the tone of voice signals partnership and respect vs. power-over and disrespect. For example, instead of “Why didn’t you take your prenatal vitamins?” you can ask something like “People have good reasons for their decisions. Help me understand more about what’s going on with prenatal vitamins for you, so I can support you in being as healthy as possible”.

Make a list of the questions that you ask patients every day. As you review them, ask yourself if there is there a way that you could ask them differently, so they are more likely to convey respect, caring and partnership.

Adopt a growth mindset towards your learning and the learning of those around you.

A learning & growth mindset for racial equity is an understanding that:

- It is possible to change our attitudes, beliefs, and behaviors.
- Racial bias is not inevitable; we can take steps to prevent racial biases from impacting us.
- Interactions with people who are different from us are opportunities to learn; they are not tests of our ability to be unbiased.

Mistakes:

- Do not mean we are bad people; it means we are humans, fallible but capable of change.
- Give us the opportunity to learn.
- Are part of growth.
- Are invitations to review what went wrong, take steps to address the things that are hampering our growth, and improve in the future

Appendix Two: Crosswalk of Our Objectives with the Specifications in CA SB464 (Dignity in Childbirth & Pregnancy Act)

Table Key	
Learning Objectives focused on Structural Competency	SC
Learning Objectives focused on Interrupting Racial Bias	IRB
Integrated Learning Objectives	IL

SB 464 Required Content	Objective Set (provided on next page)
(1) Identification of previous or current unconscious biases and misinformation.	SC.2, IRB.2
(2) Identification of personal, interpersonal, institutional, structural, and cultural barriers to inclusion.	SC.1, SC.2 IRB.1, IRB.3 IL.2
(3) Corrective measures to decrease implicit bias at the interpersonal and institutional levels, including ongoing policies and practices for that purpose.	SC.4 IRB.4 IL.3
(4) Information on the effects, including, but not limited to, ongoing personal effects, of historical and contemporary exclusion and oppression of minority communities.	SC.2 IRB.3
(5) Information about cultural identity across racial or ethnic groups.	SC.3, IL.2
(6) Information about communicating more effectively across identities, including racial, ethnic, religious, and gender identities.	SC.4 IRB.4
(7) Discussion on power dynamics and organizational decision-making.	SC.2, SC.4
(8) Discussion on health inequities within the perinatal care field, including information on how implicit bias impacts maternal and infant health outcomes.	SC.1, IRB.1, IRB.3 IL.1
(9) Perspectives of diverse, local constituency groups and experts on particular racial, identity, cultural, and provider-community relations issues in the community.	SC.4
(10) Information on reproductive justice.	SC.1, IL.3

Objective Sets

Key to the [crosswalk table](#)

SC.1

Participants will be able to:

- (a) Describe the current evidence on racial inequities in perinatal care and outcomes
- (b) Tell a story illustrating the impact of racial bias on patient experience, from the patients' eyes.
- (c) Describe the evidence regarding the provider contribution to racial inequities in care
- (d) Describe the way inequities in health care parallel the evidence of inequities in other parts of society.

Participants will also become curious about:

- (a) What caused these inequities.
- (b) What maintains inequities – why inequities persist.

SC.2

Participants will be able to:

- (a) Describe the legacy of slavery, historical and contemporary discriminatory policies, and cultural stereotypes
- (b) Define structural racism
- (c) Explain the major ways structural racism affect the lives of Black mothers, infants, and families
- (d) Describe major ways structural racism plays out in the healthcare system

SC.3

Participants will gain insight into, and empathy for the way their Black patients' expectations and interactions with health care could be affected by:

- (a) Medical mistrust
- (b) Racial trauma
- (c) Experiences of discrimination
- (d) Stereotype threat

SC.4

Participants will be able to:

- (a) Define a [color-blind philosophy](#)

- (b) Provide examples of the way a provider color-blind philosophy can undermine patient experience and provider-patient relationships
- (c) Describe 3 or more things they can do to reduce the impact of Black patients' experiences of discrimination, racial trauma, stereotype threat, on the interaction (overlaps with bias-protective strategies)
- (d) Identify 2 or more common institutional policies and procedures that have differential impact on marginalized groups
- (e) Describe examples of institutional policies and procedures that reduce inequities.

Participants will:

- (a) Write down and commit to (develop implementation intentions) 3 specific, feasible examples of actions they **will** take to reduce the impact of structural racism on Black mothers and birthing people.

IRB.1

Learners will be able to describe the current evidence on:

- (a) The contribution of provider bias to inequities in perinatal care.

IRB.2

Learners will be able to provide a basic explanation for:

- (a) Why providers are affected by structural racism in the care they provide, even though that is not consistent with their true values and motives, including:
 - x. The two separate mental systems we use to think about and make sense of other people (dual processing).
 - 1. System 1 – source of implicit (automatic, unintended, often unconscious) attitudes and behavior.
 - 2. System 2 - source of explicit (conscious, deliberate, intentional) attitudes and behavior.

IRB.3

Learners will be able to describe the implications for patient care created by:

- (a) The way that System 1 uses stored information (automatic biases and stereotypes) to:
 - xi. Rapidly shape what we expect from others
 - xii. Guide what we pay attention to - what we notice about patients
 - xiii. Affect what we recall about patients (and communicate to others)
 - xiv. Guide how we interpret patients' behavior

- xv. Create a rapid emotional response that influences our non-verbal behavior
- (b) The way implicit bias can create a negative feedback loop by...:
 - xvi. ...affecting provider non-verbal behavior, which in turn affects
 - xvii. ...patient experience and trust, which in turn affects
 - xviii. ...patient non-verbal and verbal behavior, which, affects provider behavior

Learners will be able to describe:

- (a) The relationship between provider implicit bias and patient adherence
- (b) The relationship between provider implicit bias and patient adherence

Participants will be able to identify the:

- (a) Individual factors and implicit motives that affect the likelihood that implicit racial bias will affect their interactions with and care for patient
- (b) Situational/environmental conditions that increase the likelihood that racial bias will affect patient care

IRB.4

Participants will be able to name:

- (a) The individual strategies that have been shown to work (and to not work) to prevent unintended racial biases from affecting patient care and experience.
- (b) Participants will describe specific ways they will incorporate personal bias-prevention strategies into their work with patients.
- (c) Participants will:
 - xix. Write down specific plans ([develop implementation intentions.](#)) for putting 3 or more specific, feasible, strategies into practice.

IL.1

Participants will:

- Describe two or more ways structural racism reinforces implicit racial bias
- Describe two or more ways implicit racial biases maintain structural racism.

IL.2

Participants will be able to:

- (a) review perinatal care provider questions and statements made to Black mothers and birthing people

- (b) Identify those that reflect a hidden racially biased implicit framework (set of implicit assumptions and beliefs)
- (c) Identify those that reflect structural competency (including structural and cultural humility)
- (d) Review a patient case study (patient story) and identify the way interpersonal, cultural, institutional, and structural racism affected the patients' experience and outcomes

IL.3

Participants will:

- (a) Identify the overlap between reproductive justice, professional ethics, and their closely held values
- (b) Sort concepts that are part of the definition of reproductive justice into a Venn diagram with three circles: 1. Principles of Reproductive Justice, 2. Principles embedded in my Professional Ethics, and 3. My Values, showing the overlap between the definition of reproductive justice, professional ethics, and their own closely held values.
- (c) Prepare an action plan to ensure their practice is aligned with the principles of reproductive justice, professional ethnics, and their personal values.

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