Dear Dr. Ramos,

We are writing to you as a coalition of maternal health advocates, public health experts, community organizations, physicians, midwives, and doulas deeply concerned about the recently released California's Maternal Health Care Blueprint. As key leaders, community members, and stakeholders who have been working for years to improve perinatal health outcomes in California, we appreciate your commitment to addressing maternal health and agree that this issue is of critical importance to California's women, birthing people, children, families, and communities. We must work together to bring all available resources to bear in addressing this crisis.

Our coalition represents a diverse group of individuals, clinicians, and organizations that have been at the forefront of addressing perinatal health disparities, particularly for Black, Indigenous, and other communities of color, as well as those from rural communities and communities

throughout the state that lack access to basic reproductive health care. We have serious concerns about the content, evidentiary basis, and development process of this blueprint, and strongly request a pause of the rollout of the blueprint in order to adequately address these concerns, provide transparency, and prevent harm, particularly among communities most impacted by racial inequities and limited access to reproductive health care.

Below, we outline our concerns regarding the significant omissions and oversights in the blueprint; the areas that may cause harm to communities, particularly Black and Indigenous communities; the shortcomings in the blueprint's development process; and its emphasis on placing the burden on individuals rather than addressing system failures.

Blueprint Omissions and Oversights

We were dismayed to see that the blueprint fails to:

Explicitly name and address racism as a root cause of maternal health inequities. While the document cites disparities in outcomes, it does not ground these disparities in the evidence showing systemic racism[1] as the driving factor behind these disparities. The document also fails to identify other upstream social determinants of health that intersect with or stem from racism, such as poverty, environmental exposures, and provider implicit bias[2] – factors that are important to identify and address if meaningful change is the goal. The unique challenges faced by California's Native American/Indigenous birthing communities[3] are not mentioned or addressed. Furthermore, the blueprint's race-neutral language risks further diminishing the significance of disparities in maternal health outcomes by race and ethnicity in California.

Incorporate evidence-based and/or recommended strategies to improve maternal health. The blueprint fails to include crucial strategies[4], such as increased access to midwifery care for California birthing families, community-based supports, postpartum home visits, extended paid family leave for pregnancy, and much more – many of which have been detailed by Black-led organizations in California and in perinatal health research.

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[1] U.S. Commission on Civil Rights (2021) *Statutory Enforcement Report: Racial Disparities in Maternal Health* from: https://www.usccr.gov/files/2021/09-15-Racial-Disparities-in-Maternal-Health.pdf
Chambers BD, Arega HA, Arabia SE, Taylor B, Barron RG, Gates B, Scruggs-Leach L, Scott KA, McLemore MR. Black Women's Perspectives on Structural Racism across the Reproductive Lifespan: A Conceptual Framework for Measurement Development. Matern Child Health J. 2021 Mar;25(3):402-413. doi: 10.1007/s10995-020-03074-3. Epub 2021 Jan 4. PMID: 33398713.
Chambers, B. D., Arabia, S. E., Arega, H. A., Altman, M. R., Berkowitz, R., Feuer, S. K., ... & McLemore, M. R. (2020). Exposures to structural racism and racial discrimination among pregnant and early post‐partum Black women living in Oakland, California. *Stress and Health*, *36*(2), 213-219.
Nelson, T. J., Butcher, B. D. C., Delgado, A., & McLemore, M. R. (2024). Perspectives of Certified Nurse‐Midwives and Physicians on the Structural and Institutional Barriers that Contribute to the Reproductive Inequities of Black Birthing People in the San Francisco Bay Area. *Journal of Midwifery & Women's Health*.

[2] SB-464 California Dignity in Pregnancy and Childbirth Act. Retrieved from: https://leginfo.legislature.ca.gov/faces/billCompareClient.xhtml?bill_id=201920200SB464&showamends=false

[3] Kozhimannil, K. B. (2020, May). Indigenous maternal health—a crisis demanding attention. In *JAMA Health Forum* (Vol. 1, No. 5, pp. e200517-e200517). American Medical Association.
Kozhimannil, K. B., Interrante, J. D., Tofte, A. N., & Admon, L. K. (2020). Severe maternal morbidity and mortality among indigenous women in the United States. *Obstetrics & Gynecology*, *135*(2), 294-300.

[4] Kozhimannil, K. B., Hardeman, R. R., & Henning-Smith, C. (2017, October). Maternity care access, quality, and outcomes: A systems-level perspective on research, clinical, and policy needs. In *Seminars in perinatology* (Vol. 41, No. 6, pp. 367-374). WB Saunders.

Address the critical shortages in maternity care and the growing issue of maternity care shortage areas that many communities face[5]. Without tackling these access challenges, any clinical strategies aimed at improving outcomes will inevitably be compromised.

Describe a plan to *actually transform care*[6,7] to meet the needs of communities in the currently fragmented, inequitable, and shrinking system of care. The blueprint lacks a clear vision for transforming the current system to better serve communities and make meaningful progress toward the goal of reducing preventable maternal deaths.

Acknowledge and uplift the work of Black-led organizations, and reference longstanding projects and initiatives to address maternal mortality and morbidity by people from the communities most impacted by the maternal mortality crisis. Organizations such as Black Women for Wellness[8], California Black Women's Health Project[9], the CA Coalition for Black Birth Justice Agenda[10], Beloved Birth[11]and Black Centering[12] have a deep understanding of the roots of the crisis and have been imagining, developing, disseminating, and providing solutions. The blueprint should also uplift the solutions developed by Latinx, Indigenous, and Pacific Islander organizations working to address these same forces of racism-based disparities.

Meaningfully integrate the work of key organizations and state initiatives, such as the California Maternal Quality Care Collaborative (CMQCC),[13] California Department of Public Health (CDPH)[14], and The Department of Health Care Services Birthing Care Pathways[15]. These organizations and others have the capacity to target interventions by region and demographics and are often already doing so[16]. At a minimum, the blueprint should describe this work to contextualize the full panoply of previous and current strategies in order to define the state's path forward.

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[5] Kozhimannil, Katy Backes. "Declining access to US maternity care is a systemic injustice." *bmj* 382 (2023). Kozhimannil, K. B., Interrante, M. J. D., Fritz, A. H., RD, C., Sheffield, E. C., & Carroll, C. (2024). Information for Rural Stakeholders About Access to Maternity and Obstetric Care: A Community-Relevant Synthesis of Research.

[6] *Nurture New Jersey: 2021 Strategic Plan*. (n.d.). Nurture NJ. Retrieved October 8, 2024, from https://nurturenj.nj.gov/wp-content/uploads/2021/01/20210120-At-A-Glance.pdf

[7] Dehlendorf C, Akers AY, Borrero S, et al. Evolving the Preconception Health Framework: A Call for Reproductive and Sexual Health Equity. *Obstet Gynecol*. Feb 1 2021;137(2):234-239. doi:10.1097/aog.0000000000004255

[8] Black Women for Wellness: https://bwwla.org/

[9] California Black Women's Health Project https://www.cabwhp.org/

[10] The California Black Birth Justice Agenda: https://www.cablackbirthjustice.com/blackbirthjusticeagenda2023

[11] Beloved Birth Black Centering Model of Care: https://www.alamedahealthsystem.org/family-birthing-center/black-centering/

[12] Black Centering: www.instagram.com/blackcentering/

[13] *CMQCC Maternal Quality Improvement Toolkits*. (n.d.). California Maternal Quality Care Collaborative. Retrieved October 7, 2024, from https://www.cmqcc.org/resources-tool-kits/toolkits

[14] Centering Black Mothers in California: Insights into Racism, Health, and Well-being for Black Women and Infants. Sacramento, CA: California Department of Public Health, Maternal, Child and Adolescent Health Division; 2023. Retrieved October 7, 2024, from https://www.cdph.ca.gov/Programs/CFH/DMCAH/Pages/Health-Topics/Centering-Black-Mothers.aspx; *California Pregnancy-Associated Mortality Review (CA-PAMR)*. (n.d.). California Department of Public Health. Retrieved October 8, 2024, from https://www.cdph.ca.gov/Programs/CFH/DMCAH

[15] *DHCS Birthing Care Pathway*. (n.d.). Department of Health Care Services. Retrieved October 8, 2024, from https://www.dhcs.ca.gov/CalAIM/Pages/BirthingCarePathway.aspx

[16] Nichols, C. R., & Cohen, A. K. (2021). Preventing maternal mortality in the United States: lessons from California and policy recommendations. *Journal of public health policy*, *42*(1), 127-144.

Address how to make systems trustworthy[17] rather than simply building trust in a system that upholds oppressive structures[18], e.g., the American Association of Medical Colleges (AAMC) toolkit.[19] This puts the onus and responsibility on state leaders to change the system.

Blueprint Strategies and the Potential for Harm

We are gravely concerned that the actions proposed in the blueprint stand to cause harm, particularly to the communities most impacted by inequities. The blueprint's most concrete goals center two risk assessment tools – one community-facing tool and one provider-facing tool. Both of these risk assessment tools lack strong evidence of their effectiveness in improving care, reducing mortality, and addressing disparities.

The blueprint's first goal – to have 50 percent of reproductive-age individuals in California complete an at-home pregnancy risk stratification questionnaire *before they are even pregnant* by December 2026 – is deeply concerning. Most notably, the content in its current form regarding risk designation gives the impression of personal fault and/or that individual behavior is to blame, burdening the user and discrediting the system's role in creating this crisis.[20] Furthermore, the blueprint does not describe the next steps for what happens after a risk level is designated by the patient or their care provider. What happens to the data? What are the implications of the questionnaire results on healthcare access? What guidance and support is available to a user/participant/respondent who scores as high risk? *How will the state protect such a large amount of reproductive health data from data harvesting and abuse?*[21] Finally, to our knowledge, no research supports the idea that pre-pregnancy personal risk assessment improves the outcomes or experiences of birthing people, and the blueprint provides no references to substantiate this claim.

The blueprint's second tool, universal implementation of the Obstetric Comorbidity Index (OCI) upon a person's entry into any California medical facility (Goal #2, Activity 1), with the aim of "[referring] high-risk individuals to the most suitable birthing facility based on the likelihood of complications" is similarly concerning. This tool has not been expressly validated for universal population health use, and we are not aware of any research demonstrating its effectiveness in reducing maternal mortality or morbidity. Its value

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[17] Chambers, B. D., Taylor, B., Nelson, T., Harrison, J., Bell, A., O'Leary, A., ... & McLemore, M. R. (2022). Clinicians' perspectives on racism and Black women's maternal health. *Women's Health Reports*, *3*(1), 476-482.
Scott, K. A., Britton, L., & McLemore, M. R. (2019). The ethics of perinatal care for black women: dismantling the structural racism in "mother blame" narratives. *The Journal of perinatal & neonatal nursing*, *33*(2), 108-115.

[18] Marshall, C., & Kozhimannil, K. B. (2024). Progress on Doula Access, Persistent Challenges, and Next Steps for Birth Equity. *American Journal of Public Health*, *114*(11), 1164-1166.

[19] AAMC Center For Health Justice. "Principles of Trustworthiness Toolkit Project." Accessed October 9, 2024. https://www.aamchealthjustice.org/our-work/trustworthiness/project.

[20] McLemore, Monica. "What Blame-the-Mother Stories Get Wrong about Birth Outcomes among Black Moms." USC Center for Health Journalism, March 14, 2018. https://centerforhealthjournalism.org/our-work/insights/what-blame-mother-stories-get-wrong-about-birth-outcomes-among-black-moms.

[21] Belluck, Pam and Fitzsimmons, Emma. "Abortion Data Wars: States and Cities Debate How Much Information to Collect. *The New York Times*, April 23, 2024. https://www.nytimes.com/2024/04/23/health/abortion-patient-data-privacy.html

appears limited to an improved ability to identify those at most risk for severe maternal morbidity, with a hypothetical potential for utilizing this information to target improved interventions.

We are concerned that this provider-facing risk designation tool could further marginalize high-risk populations and divert resources from struggling facilities while simultaneously overburdening higher-level facilities. Additionally, the referral process for high-risk individuals is unclear, especially as the state is already facing severe provider shortages and ongoing maternity ward closures. It is equally unclear whether facilities and providers are already referring these patients appropriately without the need for this new system.

Moreover, while we support the intention to "increase awareness of doula services, CHWs, and extended healthcare teams" (Goal #2, Activity 2) and to "[collaborate] between existing programs" (Goal #2, Activity 4), we are concerned that lack of engagement from critical partners and programs, including the undersigned, will perpetuate the blueprint's omissions rather than solve them.

We appreciate the blueprint's goal to establish a Strong Start and Beyond Fund (Goal #2, Activity 3). Bringing financial resources to address the critical issue of maternal health is vital. However, we recommend a complete overhaul of the blueprint to align with evidence-based and community-defined strategies, so that these funds are used effectively.

Shortcomings in the Blueprint Development Process

Finally, the lack of transparency behind the development process – such as the absence of details on surveys, methodology, reports, advisory committee recommendations, or listening sessions – is deeply concerning. There are few citations in the blueprint. What is clear is that the Perinatal Advisory Group (PAG) lacked key representation and failed to meaningfully engage the very communities most impacted by maternal health disparities. This strikes us as deeply flawed, and this exclusionary approach runs counter to accepted models for developing effective public health solutions.

The overrepresentation of physician and hospital perspectives on the PAG narrows the ability of crucial voices to be heard, including community advocates, doulas, promotoras, health navigators, researchers, social workers, public health experts, midwives, health plan administrators, business innovators, state leaders, and more. In terms of clinician representation alone, the process did not include participation from midwives. The contribution of midwifery and of midwife leaders is grossly undervalued in California's health care system, despite midwives making up nearly a third of birth providers in the state. Midwifery integration is recognized as a key strategy for improving outcomes, addressing provider shortages, and improving racism-based disparities in care. All of these stakeholders bring vital knowledge about the broader landscape of maternal health care and understand the deep-rooted challenges in their particular field. *Indeed it is possible that the overrepresentation of physician voices led to the overfocus on risk-based strategies rather than systems-focused strategies.*

As a result, we believe the blueprint, as currently constructed, will not effectively address California's perinatal health crisis. In fact, it risks exacerbating existing inequities and harms by placing undue burden on individuals and increasing stress and fear, rather than addressing systemic barriers.

We request a meeting with you and your team to discuss our concerns and provide recommendations for a truly equitable, evidence-based perinatal health strategy for California. In the meantime, we ask that you and your team pause any advancement of this strategy to allow time for the development of one that will improve health outcomes for all birthing families in California.

Thank you for your consideration. We look forward to hearing from you.

Sincerely,

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