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At the Intersection of Race and Health: Racial Disparities in the Maternal Healthcare System

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Sarah Schweitzer*

I. INTRODUCTION

> *"I almost died after giving birth to my daughter, Olympia. Yet I consider myself fortunate. While I had a pretty easy pregnancy, my daughter was born by emergency C-section after her heart rate dropped dramatically during contractions. The surgery went smoothly. Before I knew it, Olympia was in my arms. It was the most amazing feeling I've ever experienced in my life. But what followed just 24 hours after giving birth were six days of uncertainty."*[1]
>
> *-Serena Williams*

World-famous athlete Serena Williams depicted the delivery of her daughter as traumatic.[2] Williams entered the hospital a healthy woman, but left changed and scarred from her experience.[3] Her six days of uncertainty began with a pulmonary embolism, a condition where a blood clot blocks one or more arteries in the lungs.[4] Williams has a medical history with pulmonary embolisms, so she did not wait a single second to alert her nursing staff to her shortness of breath.[5] Her C-section stitches popped open due to the coughing—a result of the embolism—and this landed her back in

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1 Serena Williams, *What my Life-Threatening Experience Taught Me About Giving Birth*, CNN (Feb. 20, 2018, 3:32 PM), https://www.cnn.com/2018/02/20/opinions/protect-mother-pregnancy-williams-opinion/index.html [https://perma.cc/U4NH-49LN].

2 *See id.*

3 *See id.*

4 *Id.*

5 *Id.*

the operating room to prevent the clots from traveling outside of her lungs.[6] She was forced to spend the first six weeks of motherhood in bed, and she states that she feels lucky to be alive.[7] She acknowledges that she had privileges that are not afforded to many people in the same situation; she had a committed team of doctors and nurses on demand with access to medical equipment which helped save her life.[8] People in identical circumstances, who unfortunately lack access to adequate health care, often die as a result of these complications.[9]

Unfortunately, the situation that Williams endured is not an isolated incident. Just one year before Serena Williams gave birth to her daughter, a woman named Kira Johnson gave birth to her second son at a world-renowned hospital in Los Angeles.[10] After Kira gave birth to their son, Kira's husband, Charles, noticed that she was having a difficult time recovering and when he took a closer look, he noticed blood in her catheter.[11] After bringing this to the nurses' attention, a CT scan was ordered to see what was happening inside Kira's body.[12] They waited for hours while Kira's husband watched her health decline.[13] The CT scan was never performed, and seven hours later the doctor administered an internal exam in hopes of identifying the new mother's complications.[14] This was the last time Charles saw Kira alive.[15]

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6 *Id.*
7 *Id.*
8 *Id.*
9 *Id.*
10 Angela Helm, *Kira Johnson Spoke 5 Languages, Raced Cars, Was Daughter in Law of Judge Glenda Hatchett. She Still Died in Childbirth,* THE ROOT (Oct. 19, 2018, 10:03 AM), https://www.theroot.com/kira-johnson-spoke-5-languages-raced-cars-was-daughte-1829862323 [https://perma.cc/P75G-6DTY].
11 *Id.*
12 *Id.*
13 *Id.*
14 *Id.*
15 *Id.*

Kira died from a postpartum hemorrhage, which is an excess of bleeding after giving birth.[16] After the placenta is delivered, contractions typically put pressure on the bleeding vessels where the placenta was attached to stop the bleeding.[17] However, if the uterus does not contract strongly enough or if pieces of the placenta stay attached, the blood vessels bleed freely and a woman can hemorrhage.[18] The best way to treat postpartum hemorrhaging is to find the cause of the bleeding and stop it as soon as possible.[19] Kira and Charles tried to get the help they needed quickly, but their repeated requests for help within those seven hours were never answered.

There is a huge disparity in the quality of healthcare that Black women receive compared to that of their white counterparts.[20] According to the 2017 National Healthcare Quality and Disparities Report, Black patients received worse care than white patients on forty-three percent of quality measures.[21] Black patients consistently had lower numbers in receiving quality measures, which include person-centered care, patient safety, healthy living, effective treatment, care coordination, and affordable care.[22]

This comment will examine racial disparities within prenatal and postnatal access to healthcare and offer solutions to foster equity within the system. First, this comment will examine how maternal mortality of Black women has become a critical concern and how the current systems in place

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[16] Ann Evensen, Janice M. Anderson, & Patricia Fontaine, *Postpartum Hemorrhage: Prevention and Treatment,* 95 AM. FAM. PHYSICIAN 442 (2017) [hereinafter *Postpartum Hemorrhage: Prevention and Treatment*].

[17] *Postpartum Hemorrhage,* MARCH OF DIMES (Mar. 2020), https://www.marchofdimes.org/pregnancy/postpartum-hemorrhage.aspx [https://perma.cc/AW8U-KQHE].

[18] *Id.*

[19] *Id.* at 443–44.

[20] *See* GOPAL KHANNA ET AL., AGENCY FOR HEALTHCARE RSCH. AND QUALITY, 2017 NATIONAL HEALTHCARE QUALITY AND DISPARITIES REPORT 1, 16 (2017), https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/2017qdr.pdf [https://perma.cc/UV3D-BVRN].

[21] *Id.*

[22] *Id.* at 2.

perpetuate this social construct. This will be examined by looking at the history of maternal mortality among Black women nationally, as well as in Washington State, and by exploring the causes of these deaths. Second, this section will examine current law regarding multicultural health in Washington State and Medicaid for pregnant mothers and children after birth. Third, this comment proposes that Washington State implement three changes in an effort to reduce Black maternal mortality: (1) reevaluate and amend RCW 43.70.615 to require healthcare workers to take courses about bias in healthcare; (2) create new regulations that encompass social determinants of health to combat maternal mortality; and (3) extend Medicaid and Children's Health Insurance Policies for the first year of the child's life and into the fourth trimester, a term which indicates the period after giving birth.

II. BACKGROUND

The United States is facing a public health crisis of maternal mortality that disproportionately affects women of color.[23] Each year, over 700 pregnant mothers die during and after pregnancy and childbirth.[24] These numbers are astronomical, yet two-thirds of these deaths were preventable.[25] These deaths could have been prevented had health care providers followed the best medical practices to diagnose and treat

[23] Jamila Taylor et al., *Eliminating Racial Disparities in Maternal and Infant Mortality,* CTR. FOR AM. PROGRESS, (May 2, 2019), https://www.americanprogress.org/article/eliminating-racial-disparities-maternal-infant-mortality/ [https://perma.cc/6QLN-QYVP].

[24] Suzanne Delbanco et al., *The Rising U.S. Maternal Mortality Rate Demands Action from Employers*, HARV. BUS. REV., (June 28, 2019), https://hbr.org/2019/06/the-rising-u-s-maternal-mortality-rate-demands-action-from-employers [https://perma.cc/B5PZ-P4EW]; Alison Young, *Mothers Are Dying. Will This Bill Help?*, USA TODAY (Dec. 19, 2018), https://www.usatoday.com/story/news/investigations/deadly-deliveries/2018/12/19/maternal-mortality-rate-bill-targets-chidbirth-deaths/2339750002/ [https://perma.cc/5LEH-9PYG].

[25] Delbanco et al., *supra* note 24.

pregnancy complications quickly and effectively.[26] Notably, the United States falls far behind other developed countries in combatting maternal mortality. According to the World Health Organization, other developed nations, such as the Netherlands, Norway, and New Zealand, outperform the United States.[27] Specifically, the United States' maternal mortality rate is 17.4 per 100,000 live births, while the Netherlands' is 3.0, Norway's is 1.8, and New Zealand's is 1.7.[28]

In 2018, President Donald Trump signed a bill into law titled *Preventing Maternal Deaths Act of 2018*.[29] This bill required states to allocate millions of dollars to investigate maternal deaths and identify why women are dying at such an alarming rate.[30] The bill was made to establish and support state Maternal Mortality Review Committees.[31] These committees would be tasked with reviewing every pregnancy-related death and developing recommendations for how to prevent these deaths in the future.[32] This bill gives the appearance that the United States is taking a step in the right direction to decrease maternal mortality rates; however, it misses the mark. The bill perpetuates the idea that the blame should be placed onto the mothers instead of the system. The bill does not address whether flawed medical care played a role in the deaths of these women.[33] Although so many of these deaths could have been prevented by quick and efficient diagnoses, many states avoided scrutinizing the medical care that occurred

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[26] *See* Delbanco et al., *supra* note 24; *see also* Young, *supra* note 24.

[27] Roosa Tikkanen et al., *Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries,* THE COMMONWEALTH FUND, (Nov. 10, 2020), https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries [https://perma.cc/HTE4-QVFQ].

[28] *Id.*

[29] 42 U.S.C. § 247b–12.

[30] Young, *supra* note 24.

[31] 42 U.S.C. § 247b–12(a)(1).

[32] Press Release, Diana DeGette & Jaime Beutler, House of Representatives, Bipartisan Bill to Prevent Maternal Deaths Passes U.S. House (Dec. 11, 2018).

[33] Young, *supra* note 24.

in the days, hours, and minutes leading up to the death of a mother.[34] Instead, many reports focused on the lifestyle habits of the mother, such as "women being obese, smoking or failure to seek prenatal care, or failure to use seatbelts."[35] Many supporters of the bill stated that this was a good first step in determining why women are dying at such astronomical rates from childbirth and pregnancy-related complications.[36] Supporters applauded the bill because it gave states the resources to investigate every maternal death so that we can begin to understand why women are dying and can aim specifically to prevent these tragedies in the future. However, this bill is insufficient because it ignores the significant impact that our healthcare system has on maternal health.

A. Maternal Health for Black Women in the United States and Washington State

Maternal health is a human right.[37] Maternal mortality is a human rights issue. Maternal deaths are preventable.[38] These deaths are perpetuated by our nation's failure to protect basic human rights, including every individual's right to life, the right to freedom from discrimination, and the right to the highest attainable standard of health.[39] According to the human rights principles outlined by the federal government, the health care system must provide services that are available, accessible, acceptable, and of good quality for every person who walks through hospital doors.[40] Yet, racial

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[34] *Id.*
[35] *Id.*
[36] *Id.*
[37] UNITED NATIONS., UNIVERSAL DECLARATION OF HUMAN RIGHTS, https://www.un.org/en/about-us/universal-declaration-of-human-rights [https://perma.cc/V57D-CN9Y].
[38] AMNESTY INT'L, DEADLY DELIVERY: THE MATERNAL HEALTH CARE CRISIS IN THE USA 3 (2009).
[39] *Id.* at 13.
[40] *Id.* at 7.

disparities in healthcare reveal the truth that this is not the current standard in the United States.

Fundamental human rights violations occur when suffering is preventable but is not prevented.[41] These violations are a result of the preventable failures that contribute to maternal death, illness, injury, mistreatment, abuse, discrimination, and denial of information and bodily autonomy.[42] Look at what happened to Kira. Her human rights were violated when she was forced to sit in a hospital for seven hours before receiving care. Human rights are continuously violated, and women of color are still dying in childbirth due to pregnancy-related complications.[43] Research by the World Health Organization recently found that the United States is one of thirteen countries with a rising maternal mortality rate, yet the United States is the only country on that list with an advanced economy.[44]

The Black Mamas Matter Alliance created a toolkit that outlines governmental duties to ensure safe and respectful maternal health.[45] First, governments must respect and refrain from interfering with women's access to the services they need.[46] This includes healthcare services, safe communities to raise children, affordable housing, employment, and social support.[47] Second, the government must prevent third parties from interfering with the right of maternal care, including prenatal, birth, and

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[41] BLACK MAMAS MATTER ALLIANCE AND CENTER FOR REPRODUCTIVE RIGHTS, BLACK MAMAS MATTER: ADVANCING THE HUMAN RIGHT TO SAFE AND RESPECTFUL MATERNAL HEALTH CARE 9 (2016), http://blackmamasmatter.org/wp-content/uploads/2018/05/USPA_BMMA_Toolkit_Booklet-Final-Update_Web-Pages-1.pdf [https://perma.cc/3JVG-J7W9] [hereinafter *Black Mamas Matter*].

[42] *Id.*

[43] *Id.*

[44] Roosa Tikkanen et al., MATERNAL MORTALITY AND MATERNITY CARE IN THE UNITED STATES COMPARED TO 10 OTHER DEVELOPED COUNTRIES, (Nov. 2020) https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries [https://perma.cc/4NPJ-7QAG].

[45] *Black Mamas Matter, supra* note 41, at 4–5.

[46] *Id.* at 10.

[47] *Id.*

postpartum care.[48] The Black Mamas Matter Alliance states that those who violate these women's rights should be investigated and sanctioned.[49] Third, they state that the government must begin taking positive steps towards respectful and safe maternal care.[50] This includes passing legislation, ensuring adequate funding programs, and training healthcare providers.[51] These are real women who are dealing with a very real issue and are working to put a stop to Black mothers dying while having children.

1. National and State Level Statistics

Between 2007 and 2016, the Centers for Disease Control and Prevention (CDC) collected data on maternal mortality rates within the United States.[52] They studied Pregnancy-Related Mortality Ratios (PRMR) by "demographic characteristics and state PRMR tertiles (i.e., states with the lowest, middle and highest PRMR);"[53] pregnancy-related death rates for women over thirty years old are four to five times higher among Black mothers than white mothers.[54] From 2007–2008 and 2015–2016, PRMR increased across the United States from 15.0 to 17.0 per 100,000 live births.[55] From this study, researchers found that the overall PRMR was 16.7 pregnancy-related deaths per 100,000 live births.[56] However, this data was not consistent across all races and ethnicities.[57] Black mothers experience a

48 *Id.*
49 *Id.*
50 *Id.*
51 *Id.*
52 EMILY E. PETERSEN ET AL., CTRS. FOR DISEASE CONTROL & PREVENTION, MORBIDITY AND MORTALITY WEEKLY REPORT: RACIAL/ETHNIC DISPARITIES IN PREGNANCY-RELATED DEATHS – UNITED STATES, *2007–2016,* at 762 (Sept. 6, 2019), https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6835a3-H.pdf [https://perma.cc/34KT-ERCY].
53 *Id.* (A tertile is defined as "either of the two points that divide an ordered distribution into three parts, each containing a third of the population.").
54 *Id.*
55 *Id.*
56 *Id.*
57 *Id.* at 762–63.

PRMR of 40.8 pregnancy-related deaths per 100,000 live births, the highest of all racial and ethnic groups.[58] These disparities increase as mothers age, yet they are present at all education levels.[59] Black women with a college education have a PRMR 5.2 times that of white women with the same level of education.[60]

Although Washington State is doing better than other states in the U.S., pregnant mothers are still dying at a disproportionate rate.[61] Between 2014 and 2016, 268,050 babies were born in Washington.[62] However, in those three years there were 11.2 pregnancy-related maternal deaths for every 100,000 live births, including deaths from suicide and overdoses.[63] In that same time period, there were sixty-two pregnancy-associated deaths per 100,000 Black mothers who suffered pregnancy related deaths.[64] The DOH found that

> Natural manner of deaths made up the largest proportion for the total maternal deaths (thirty-nine percent), and included hemorrhage, hypertensive disorders, infection, pulmonary conditions, embolism, cardiomyopathy, gastrointestinal disorders, and cancer.[65] Deaths from injuries such as motor vehicle accidents accounted for nearly a quarter of deaths (twenty-three percent), followed by accidental substance overdose (prescription and illicit drugs, and alcohol) (fifteen percent).[66] Suicide manner of death represented thirteen percent, and homicide manner of death represented ten percent of the total deaths.[67]

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[58] *Id.* at 763.
[59] *Id.*
[60] *Id.*
[61] WASH. DEP'T OF HEALTH, WASHINGTON STATE MATERNAL MORTALITY REVIEW PANEL: MATERNAL DEATHS 2014-2016, at 16 (2019) [hereinafter MATERNAL MORTALITY REVIEW PANEL].
[62] *Id.*
[63] *Id.*
[64] *Id.* at 67.
[65] *Id.* at 19.
[66] *Id.* at 19–20.
[67] *Id.* at 20.

B. Causes for Disparities in Maternal Health Between White and Black Women

Mental health problems before pregnancy and after childbirth are extremely common.[68] Although mental health incidents are less probable to occur during pregnancy, anxiety and depression during and after pregnancy are common.[69] Pregnant mothers with mental illnesses are more likely to have complications.[70] Women who suffer from depression or panic disorders are at a higher risk for suicide, low birth weight, and emergency cesarean sections when compared to women who do not have these disorders.[71] Consequences of mental illnesses for mothers during the perinatal period include preterm labor, obstetric complications, increased mental health symptoms, visits to physicians, hospital admissions, and negative childbirth experiences.[72] Substance abuse and mental illness contributed to at least twenty-five percent of maternal deaths in Washington State between 2014 and 2015, with many more women having undiagnosed mental illnesses or misdiagnosis of symptoms.[73] One in six Americans suffer from a diagnosable mental health disorder.[74] "African-Americans, Hispanics, Asian-Americans and Native-Americans . . . are more likely to

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[68] DEP'T OF MENTAL HEALTH & SUBSTANCE ABUSE, WORLD HEALTH ORG., MILLENNIUM DEVELOPMENT GOAL 5: IMPROVING MATERNAL MENTAL HEALTH 2 (2008), https://www.who.int/mental_health/prevention/suicide/Perinatal_depression_mmh_final.pdf [https://perma.cc/9R5M-GKCB] [hereinafter MILLENNIUM DEVELOPMENT GOAL 5].

[69] Margaret Oates, *Perinatal Psychiatric Disorders: A Leading Cause of Maternal Morbidity and Mortality,* 67 BRITISH MED. BULL. 219, 221 (2003).

[70] *See* WASH. STATE DEP'T OF HEALTH, *Maternal Mortality Review: A Report on Maternal Deaths in Washington 2014-2015,* at 30–31 (July 2017), https://www.doh.wa.gov/Portals/1/Documents/Pubs/140-154-MMRReport.pdf [https://perma.cc/YR3Z-4GP9].

[71] *See id.* at 9.

[72] MILLENNIUM DEVELOPMENT GOAL 5, *supra* note 68.

[73] MATERNAL MORTALITY REVIEW PANEL, *supra* note 61, at 46.

[74] *Understanding Barriers to Minority Mental Health Care,* UNIV. OF S. CAL. DEP'T OF NURSING (May 10, 2018), https://nursing.usc.edu/blog/discrimination-bad-health-minority-mental-healthcare [https://perma.cc/P864-KCTV].

experience the risk factors that can cause [severe] mental health disorders," including depression.[75]

The DOH founded the Maternal Mortality Review Panel and found that the quality and timeliness of postpartum follow-up care for many of the women was a contributing factor in their deaths and indicates gaps in services and care during this time. This period usually refers to the first six weeks (forty-two days) after delivery or the end of pregnancy.[76] The review panel found significant gaps in care and identified numerous circumstances where members of a care team could have and should have intervened.[77] New mothers are already vulnerable to conditions such as depression and complications from postpartum eclampsia during the first six weeks after delivery.[78] Specifically, research shows that thirty-three percent of pregnancy-related deaths occur during the postpartum period.[79]

Additionally, postpartum depression has been found to affect over ten percent of women in their reproductive age, but many new mothers do not experience severe symptoms until up to six weeks postpartum.[80] Women in the postpartum period are at a greater risk for depression and suicide compared to women who are still pregnant.[81] This risk is heightened when a mother has a mental health diagnosis, including postpartum depression, mood disorders, or substance use disorders.[82] Both postpartum depression and pregnancy-related eclampsia can be treated if screened for in time.[83]

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[75] *Id.*
[76] *See* Ching-Yu Cheng et al., *Postpartum Maternal Health Care in the United States: A Critical Review,* JOURNAL OF PERINATAL EDUCATION 34 (2006).
[77] *Id.* at 9.
[78] *See id.* at 23.
[79] *Id.* at 24.
[80] *See Depression During Pregnancy,* POSTPARTUM SUPPORT INT'L (Feb. 28, 2022, 1:22 PM), https://www.postpartum.net/learn-more/depression [https://perma.cc/3CMB-URVA].
[81] MATERNAL MORTALITY REVIEW PANEL, *supra* note 61, at 29.
[82] *See id.* at 31.
[83] *See id.* at 36, 45.

The MMRP calls this time period the "key to maternal mortality" because there are so many opportunities for intervention to save mothers' lives.[84]

C. Social Determinants of Health and How They Improve Health Outcomes

Social determinants of health refer to the conditions in the places where we live, work, learn, and socialize that affect health risks and outcomes.[85] Social determinants of health can be grouped into five key areas: (1) economic stability; (2) education access and quality; (3) healthcare access and quality; (4) neighborhood and built environments; and (5) social and community contexts.[86] Some examples of social determinants of health are safe housing, discrimination, education, violence, access to nutritious foods and physical activity opportunities, and language and literacy skills.[87] In Washington, the DOH tracks five social determinants of health by county: (1) poverty; (2) education; (3) limited English; (4) unemployment; and (5) uninsured.[88]

Social determinants of health contribute to a wide disparity and inequalities seen in our health.[89] For example, if a family does not have access to quality foods, they are less likely to have adequate nutrition which

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[84] *See* WASH. STATE DEP'T OF HEALTH, MATERNAL MORTALITY REVIEW: A REPORT ON MATERNAL DEATHS IN WASHINGTON 2014–2015, at 30 (July 2017), https://doh.wa.gov/sites/default/files/legacy/Documents/Pubs//140-154-MMRReport.pdf [https://perma.cc/ERH5-YXNE].

[85] *What Are Social Determinants of Health?*, CTRS. FOR DISEASE CONTROL & PREVENTION (Mar. 10, 2021), https://www.cdc.gov/socialdeterminants/about.html [https://perma.cc/CZ32-7U2C].

[86] *Id.*

[87] Office of Disease Prevention & Health Promotion, *Social Determinants of Health*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://health.gov/healthypeople/objectives-and-data/social-determinants-health [https://perma.cc/MZR9-L2ZM].

[88] *Social Determinants of Health Data,* WASH. STATE DEP'T OF HEALTH, https://doh.wa.gov/data-statistical-reports/washington-tracking-network-wtn/social-determinants-health [https://perma.cc/4WKS-3PE3] [hereinafter *Social Determinants of Health Data*].

[89] Office of Disease Prevention & Health Promotion, *supra* note 87.

raises their risk of conditions like heart disease, diabetes, and obesity.[90] Health can also be socially determined by access to education; individuals have increased difficulty getting into college or getting a high paying job due to inadequate access to a quality education from a young age. Though it is not impossible for that person to get a high paying job, it is more difficult because it puts them behind other potential candidates who received quality education. In other words, it is similar to starting a race after another competitor has been running for ten minutes.

Social determinants of health are incredibly important when looking to increase a person's health status. While enhancing quality of life positively affects health outcomes, factors such as poverty, education, access to adequate food and water, and access to health care are interdependent factors that explain why some people have worse health outcomes than others.[91] These social conditions are not the only determinants that negatively affect a person's health; societal factors such as racism and other types of oppression can also have a tremendous impact.[92] Marginalized groups, such as people of color and people in the LGBTQ+ community, are more likely to have worse health outcomes.[93]

In Washington, the DOH uses Accountable Communities of Health (ACH) to bring health leaders together to improve health equity.[94] ACH provides links for coordination and integration to support the environment and address the needs of the people they come into contact with.[95] The top five sectors of ACH are behavioral health providers and organizers, primary

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[90] *Id.*
[91] *Social Determinants of Health Data, supra* note 88; Office of Disease Prevention & Health Promotion, *supra* note 87.
[92] *Social Determinants of Health Data, supra* note 88.
[93] *Id.*
[94] *Accountable Communities of Health (ACH),* WASH. STATE HEALTH CARE AUTH. (Nov. 30, 2020, 11:49 AM), https://www.hca.wa.gov/about-hca/medicaid-transformation-project-mtp/accountable-communities-health-achs [https://perma.cc/KQ6A-BX4C].
[95] *Id.*

care, community-based organizations, hospital/health systems, and local government.[96] Those who participate in ACH are asked to identify which sector they represent, and the top five sectors selected by respondents were also the sectors most frequently chosen for each individual ACH.[97] Continuing to focus on social determinants of health through the ACH program will show Washington legislators and community members how they can help marginalized communities improve their health, including the health of those who are pregnant.

D. Washington State Legislation, Medicaid, and CHIP

Many states have statutes and regulations regarding maternal health, and Washington is no exception. First, this comment will analyze what the Washington State Legislature currently has in place to improve maternal health. Next, this comment will analyze and explain Medicaid and how it works within Washington. Lastly, this comment will look at the Children's Health Insurance Program (CHIP), and how it works to bring adequate healthcare to children in Washington.

1. Washington State Legislature

Washington currently has a statute that requires continued education for medical professionals. RCW 43.70.615, also known as the Multicultural Health Awareness and Education Program—Integration into Health Professions Basic Education Preparation Curriculum, establishes the "multicultural health awareness and education program as an integral part of its health professions regulation."[98] The Legislature enacted this statute to foster healthcare providers' knowledge, understanding, and skillsets

[96] CTR. FOR CMTY. HEALTH & EVALUATION, ACH PARTICIPANT SURVEY 2018, WASH. STATE HEALTH CARE AUTH. 4–5 (2019), https://www.hca.wa.gov/assets/program/ach-participant-survey-2018.pdf [https://perma.cc/8AZM-Q6SW].
[97] *Id.* at 4.
[98] WASH. REV. CODE § 43.70.615(2).

regarding serving patients from diverse populations.[99] In the notes section of the statute, the Legislature found that "women and people of color experience significant disparities from the general population in education, employment, healthy living conditions, access to health care, and other social determinants of health."[100] The Legislature decided that health professionals needed to prioritize maternal health.[101] The law required that by July 1, 2008, each education program that trains health professionals must integrate instruction on multicultural health.[102]

Although RCW 43.70.615 increased cultural competency requirements in specific aspects of healthcare, the Legislature must continue to expand cultural competency requirements because, contrary to what was expected, the numbers of pregnancy-related deaths have increased.[103] Washington added legislation that requires cultural competence education for optometrists, pharmacy technicians, orthopedics, and language interpreters.[104] Healthcare workers in these areas must have education and training in a multicultural health curriculum to increase their understanding of how different cultures see healthcare and to provide the best care possible when people in these cultures need to receive help.[105] When the Washington State Legislature enacted the statute in 2008, the MMR in Washington was approximately 30 deaths per 100,000 live births.[106] However, in 2015, the ratio increased to 38.9 deaths per 100,000 live births.[107]

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[99] WASH. REV. CODE § 43.70.615(2).
[100] WASH. REV. CODE § 43.70.615.
[101] *See* WASH. REV. CODE § 43.70.615(1).
[102] WASH. REV. CODE § 43.70.615(3).
[103] *See generally* WASH. DEP'T OF HEALTH, *supra* note 70, at 7.
[104] WASH. ADMIN. CODE § 246-851-235 (2005); WASH. ADMIN. CODE § 246-945-215 (2020); Frank M. McClellan et al., *It Takes a Village: Reforming Law to Promote Health Literacy and Reduce Orthopedic Health Disparities,* 8 J. HEALTH & BIOMEDICAL L. 333, 359 (2013).
[105] *See* McClellan et al., *supra* note 104, at 358–59.
[106] WASH. DEP'T OF HEALTH, *supra* note 70, at 7.
[107] *Id.* at 16.

California saw improvement in their MMR after enacting a statute addressing maternal health.[108] The California State Legislature passed a bill with the same end goal: to ensure that doctors are aware of their own biases and that they strive to be culturally competent.[109] Medical providers in California are required to continue their education in the following areas: (1) prevention of chronic diseases; (2) treatment of chronic diseases; and (3) application of changes in nutrition and lifestyle behavior.[110] However, in addition to continuing education in these areas, medical providers are required to take continuing education courses containing cultural and linguistic competency within medicine.[111] The California Legislature gives specific recommendations of classes that encompass cultural competency, which include the following: (1) applying linguistic skills to communicate effectively with the target population; (2) utilizing cultural information to establish therapeutic relationships; (3) incorporating pertinent cultural data within diagnosis and treatments; and (4) understanding and applying cultural and ethnic data in the treatment of those in the LGBTQ+ community.[112] Between 2011 (when the statute was enacted) and now, California has seen rates far below the United States' rate of 11.2 deaths per 100,000[113] live births with an MMR of 7.3 per 100,000.[114] California diligently works to decrease the number of women who die due to pregnancy and childbirth. One mother in California who almost died in childbirth is leading the charge by asking to petition the Food and Drug

[108] *See generally* CAL. BUS. & PROF. CODE § 2190.1 (2020).
[109] *See id.*
[110] *Id.*
[111] *Id.*
[112] *Id.*
[113] *See generally* Donna Hoyert, *Maternal Mortality Rates in the United States,* NATIONAL CENTER FOR HEALTH STATISTICS,1 (Feb. 2020).
[114] *See generally* Tara O'Neill Hayes & Carly McNeil, *Maternal Mortality in the United States,* AM. ACTION F. (Sept. 9, 2019), https://www.americanactionforum.org/insight/maternal-mortality-in-the-united-states/ [https://perma.cc/DH45-B28B].

Administration (FDA) to restrict the use of certain drugs that are not FDA approved for labor and delivery uses but are nevertheless being used on Black women to induce labor.[115]

On September 23, 2021, the DOH announced the implementation of a Senate Substitute Bill that would increase equity training for health care providers.[116] The DOH is considering creating rules that require health professionals who are licensed under Title 18 to complete health equity continuing education training, as well as establish minimum standards for health equity continuing education programs to help implement Engrossed Senate Substitute Bill 5229 (ESSB 5229).[117] This bill directs the department to adopt rules requiring a licensee to complete health equity training at least once every four years.[118] Section 2 of ESSB 5229 directs the department to consult with patients or communities with lived experiences of health inequities or racism in the health care system when developing model rules.[119] The DOH has not yet developed these rules, but creating rules to implement ESSB 5229 is pivotal to prioritizing health outcomes.

2. Medicaid

Medicaid is a program that provides free or low-cost health insurance for millions of low-income families and children, pregnant women, the elderly, and people with disabilities.[120] Although eligibility guidelines are typically set up by the federal government, state governments can set up their own

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[115] Jacqueline Howard, *The US has the Highest Maternal Death Rate of any Developed Nation. California is Trying to do Something About That*, CNN HEALTH (Apr. 16, 2020, 9:22 AM), https://www.cnn.com/2020/04/14/health/maternal-deaths-california/index.html [https://perma.cc/BD4S-NMSL].
[116] S.B. 5229, 67th Leg., Reg. Sess. (Wash. 2021).
[117] E.S.S.B 5229, 67th Leg., Reg. Sess. (Wash. 2022).
[118] *Id.*
[119] *Id.*
[120] *Medicaid and CHIP Coverage,* HEALTHCARE.GOV, https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ [https://perma.cc/47U8-3KU6].

requirements for eligibility.[121] States are required to include certain individuals in their Medicaid plan: groups who are categorically needy, medically needy, and special groups.[122] Pregnant women with income levels at or below 133% of the federal poverty level fall into the categorically needy group.[123] If a pregnant woman's income is too high to qualify for Medicaid under the categorically needy group, she can still qualify for Medicaid under the medically needy group.[124] To qualify for Medicaid, offices typically require individuals to present certain documentation including proof of pregnancy; proof of citizenship if a U.S. citizen; proof of non-citizenship if not a U.S. citizen; and proof of income.[125]

Medicaid works similarly to other medical insurance programs; there are certain medical providers who have a contract to treat people with Medicaid.[126] Not all clinics are required to accept Medicaid insurance. As a result, individuals on Medicaid could face out of pocket costs if they do not verify in advance that their healthcare provider is contracted for Medicaid. Pregnant women are covered under Medicaid "for all care related to the pregnancy, delivery and any complications that may occur during pregnancy and up to 60 days postpartum."[127] Additionally, pregnant women may qualify for presumptive eligibility, which covers care the women received for their pregnancy before they established Medicaid coverage.[128]

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[121] *Policy Basics: Introduction to Medicaid,* CENTER ON BUDGET AND POLICY PRIORITIES, https://www.cbpp.org/research/health/introduction-to-medicaid [https://perma.cc/D6YJ-3NBP].
[122] *Medicaid for Pregnant Women,* AM. PREGNANCY ASS'N, https://americanpregnancy.org/healthy-pregnancy/planning/medicaid-for-pregnant-women/ [https://perma.cc/FDP9-YSKQ].
[123] *Id.*
[124] *Id.*
[125] *Id.*
[126] *Id.*
[127] *Id.*
[128] *Id.*

In Washington, pregnant women on Medicaid receive coverage under Washington Apple Health.[129] In order to be eligible for care under Washington State's Health Care Authority, women must show proof of pregnancy and documentation of income at or below the Medicaid standard.[130] These standards are set forth depending on the size of a household: for a single person, there is no monthly income maximum; for a two-person household, the monthly maximum is $2,845; for a three-person household, the monthly maximum is $3,584; and so on until it reaches seven-person households.[131] The household size includes "yourself, the number of unborn children, and the number of additional household members (e.g., an individual living alone and pregnant with twins is considered a three-person household)."[132] In Washington, a woman is covered for sixty days after the end of the pregnancy plus any additional days left during the month.[133]

3. CHIP

The Children's Health Insurance Program (CHIP) provides health coverage for children through both Medicaid and separate CHIP programs.[134] In 2018, 9.6 million children were enrolled in CHIP programs.[135] These programs target low-income pregnant women; CHIP is similar to Medicaid because they both provide health coverage to children and families who cannot afford private healthcare.[136] There are few

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[129] *Pregnant Individuals,* WASH. STATE HEALTH CARE AUTH., https://www.hca.wa.gov/health-care-services-and-supports/apple-health-medicaid-coverage/pregnant-individuals [https://perma.cc/RA9P-2CND].
[130] *Id.*
[131] *Id.*
[132] *Id.*
[133] *Id.*
[134] *Medicaid and CHIP Coverage*, *supra* note 120.
[135] *Children's Health Insurance Program (CHIP),* HEALTHCARE.GOV, https://www.medicaid.gov/chip/index.html [https://perma.cc/J3R4-TY9U].
[136] CHILD HEALTH DIVISION, CHILDREN'S DEFENSE FUND, THE ACCESS HANDBOOK, CHIP AND MEDICAID 1 (2005).

differences between Medicaid and CHIP, and typically CHIP is used to expand Medicaid coverage to families who make too much in annual income to qualify for Medicaid benefits.[137] CHIP provides healthcare to more than 50,000 children in Washington.[138] To many families who rely on CHIP, quality medical care would be out of reach without it due to the costs. Under CHIP in Washington, children can receive care up until age 19 as long as their family income is at or below the Medicaid standard outlined above.[139]

Although there are many positive impacts that come with Medicaid and CHIP, the programs are not perfect. For instance, because Medicaid only covers through the first six months postpartum, many mothers do not get the care they need in the year after giving birth.[140] Additionally, a majority of mothers who had pregnancy-associated deaths from suicide were insured through Medicaid.[141] Women with private health insurance during pregnancy and up to one year postpartum had a drastically lower maternal mortality ratio than women who were covered through Medicaid.[142]

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[137] *Id.* at 2.
[138] *Children's Health Insurance Plan (CHIP) keeps healthcare affordable for families,* WASH. STATE HEALTH CARE AUTH., https://www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage/children-s-health-insurance-program-chip [https://perma.cc/3RUH-FAMB].
[139] WASH. APPLE HEALTH, ELIGIBILITY OVERVIEW, WASHINGTON APPLE HEALTH (MEDICAID) PROGRAMS 5 (Apr. 2021), https://www.hca.wa.gov/assets/free-or-low-cost/22-315.pdf [https://perma.cc/P5FE-4W2C].
[140] *See generally* Usha Ranji et al., *Expanding Postpartum Medicaid,* KAISER FAMILY FOUND. (Mar. 9, 2021), https://www.kff.org/womens-health-policy/issue-brief/expanding-postpartum-medicaid-coverage/ [https://perma.cc/ARP3-DWCJ].
[141] MATERNAL MORTALITY REVIEW PANEL, *supra* note 61, at 25.
[142] *Id.* at 30.

III. Proposed Solutions to Combat Implicit and Explicit Biases Within Healthcare

The massive racial disparity for pregnant persons of color who die in childbirth is undeniable. All women should be able to go to the hospital for the birth of their child without being at higher risk of losing their lives because of something they cannot control—their skin color. Though this is not the case, there are realistic and impactful remedies that may be implemented. First, Washington must amend RCW 43.70.615 to require healthcare workers to take ongoing educational courses about implicit and explicit biases in healthcare. Second, Washington must create regulations that encompass both social determinants of health and Accountable Communities of Health. Third, Washington State must extend Medicaid and CHIP throughout the first year of the child's life and ongoing through the fourth trimester.

A. Amend RCW 43.70.615

RCW 43.70.615 nods at the importance of integrating racial equity education in the healthcare field. However, the statute has two specific shortcomings. First, the statute does not consider implicit biases of healthcare professionals. Second, the statute does not require continued education once a person becomes a healthcare professional. Once the statute is amended to include these concepts, Washington can begin to work towards decreasing its MMR and keeping women safe and healthy during pregnancy and childbirth. The current statute reads as follows:

> The department . . . shall establish, within available department general funds, an ongoing multicultural health awareness and education program as an integral part of its health professions regulation . . . Any such education shall be developed in

> collaboration with education programs that train students in that health profession.[143]

As part of this legislation, all professions regulated by the Washington State DOH were required to incorporate multicultural education into their basic curriculum by July 1, 2008.[144] The legislation's intent is to educate students going into healthcare about racial disparities, implicit and explicit biases, and the experiences of people of color within healthcare.[145] The statute took effect in 2008; however, the Legislature must amend it.

To create racial equity, the statute must include information regarding biases. The statute misses the mark in its intent, which is to educate healthcare workers on their own biases. A bias is a tendency, inclination, or prejudice toward or against something or someone.[146] Implicit biases are stereotypes that unconsciously affect our understanding, actions, and decisions.[147] While implicit biases are rooted in our subconscious, explicit biases are processed in the brain "at a conscious level as declarative, semantic memory, and in words."[148] Combatting healthcare workers' biases requires ongoing and consistent efforts.[149] Attacking these biases is best achieved through education and self-reflection of providers.[150] When providers understand their own biases, they are more equipped to keep those biases out of their work at hospitals and in-care facilities.[151] Education

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[143] WASH. REV. CODE § 43.70.615(2) (2021).
[144] WASH. REV. CODE § 43.70.615(3) (2006).
[145] S.B. 6194, 59th Leg., Reg. Sess. (Wash. 2006).
[146] *Bias,* MERRIAM WEBSTER DICTIONARY (2020), https://www.merriam-webster.com/dictionary/bias [https://perma.cc/RLC6-J7GG].
[147] *Understanding Implicit Bias,* KIRWAN INST. FOR THE STUDY OF RACE AND ETHNICITY, https://kirwaninstitute.osu.edu/article/understanding-implicit-bias [https://perma.cc/9XKL-M8R5].
[148] NAT'L CTR. FOR CULTURAL COMPETENCE, *Two Types of Bias,* GEO. CTR. FOR CHILD AND HUM. DEV. 3, https://nccc.georgetown.edu/bias/module-3/1.php [https://perma.cc/HU3C-7RGF].
[149] *See* Chloë FitzGerald & Samia Hurst, *Implicit Bias in Healthcare Professionals: A Systematic Review,* BMC MED. ETHICS 2 (2017).
[150] *See id.*
[151] *See id.*

and training programs targeted at healthcare professionals can mitigate adverse impacts of implicit biases in the health care sector.[152] These programs should be used to ensure that providers remain impartial no matter the race, ethnicity, or gender of a patient.[153] Extending these programs throughout a healthcare professional's career will increase their knowledge and understanding of biases which will hopefully extend into their practices. This requirement would need to be implemented by each individual hospital, but the DOH must partner with equity groups in Washington to create a curriculum that includes informative and accurate trainings. Therefore, amending RCW 43.70.615 to require ongoing education throughout healthcare professionals' careers will notify the practitioners of their individual biases, and this edification should improve the experience of Black women who give birth in these hospitals.

Although this statute is important and is a great first step, it is time that Washington goes a step further. Cultural competency for healthcare providers must be included in the amendment of this statute.[154] Cultural competency education in healthcare aims to ensure that all people get equitable and efficient healthcare regardless of race, culture, or gender.[155] Many states have passed legislation to include cultural competency in medical professional's continuing education courses.[156]

Healthcare professionals in California are required by statute to engage in ongoing education for cultural competency.[157] This California statute also

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[152] INST. FOR HEALTHCARE IMPROVEMENT, *How to Reduce Implicit Bias,* IMPROVEMENT BLOG (Sept. 28, 2017), http://www.ihi.org/communities/blogs/how-to-reduce-implicit-bias [https://perma.cc/2U9F-RUFR].
[153] *See id.*
[154] *See* AMNESTY INT'L, supra note 38, at 2.
[155] *See* Lidia Horvat et al., *Cultural Competence Education for Health Professionals,* COCHRANE DATABASE SYS. REV. (2014).
[156] *See* CAL. BUS. & PROF. CODE § 2190 (2012); H.B. 2011, 80th Leg., Reg. Sess. (Or. 2019).
[157] *See* CAL. BUS. & PROF. CODE § 2190 (2012).

mandates continued education throughout the practitioner's career.[158] As a result of this mandate, California MMRs have decreased.[159] Studies show that continued education in cultural competency improves knowledge, attitudes, and skills of health professionals, and increases patient satisfaction.[160] A culturally competent healthcare system can drastically improve health outcomes and quality of care while simultaneously working to eliminate racial and ethnic health disparities.[161]

To combat issues of racial disparities in childbirth, Washington should amend RCW 43.70.615 to encompass cultural competency in medical providers' continued education programs. The addition to the statute should read as follows:

> The department … shall establish, within available department general funds, an ongoing multicultural health awareness and education program as an integral part of its health professions regulation. … Any such education shall be developed in collaboration with education programs that train students in that health profession. A disciplining authority may require that instructors of continuing education or continuing competency programs integrate multicultural health into their curricula when it is appropriate to the subject matter of the instruction. *After the student becomes a medical professional, they are required to take continuing medical education courses to develop, maintain, and increase cultural competency in the healthcare sphere. (emphasis added)*

This addition integrates cultural competency education throughout a healthcare professional's schooling and continues through their career. This is likely to have the same positive impact as the California statute and will

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[158] *See id.*
[159] *See generally* Hayes & McNeil, *supra* note 114, at 8.
[160] *See* Mary Catherine Beach et al., *Cultural Competency: A Systematic Review of Healthcare Provider Educational Interventions,* NAT'L INST. OF HEALTH 356 (2005).
[161] Health Pol'y Inst., *Cultural Competence in Health Care: Is it Important for People with Chronis Conditions?*, GEO. U., https://hpi.georgetown.edu/cultural/ [https://perma.cc/KES9-DS5N].

result in saving the lives of many minority individuals who go to hospitals seeking care.[162]

The rulemaking proposed by the Washington DOH is a quality first step forward; however, the rules have yet to be written and we must work for change now. There must be specific training for OB/GYNs and those who work on Labor and Delivery units, and this proposed rulemaking may be too generalized to get to the root problem of increased rates of maternal mortality in Black communities. The rulemaking committee must take these findings into consideration when beginning to draft the new rules.

B. Create Regulations That Include Social Determinants of Health and ACH

Because of the impact the measures listed above have on health, Washington must write and implement regulations that include ACH and increased funding to cultural competency training programs. Currently, there is no regulation that encompasses ACH with the addition of maternal health.[163] Washington has created a program called Healthier Washington,[164] which aims to build the state's capacity to move health care spending from volume to value, improve the health of state residents, and deliver coordinated whole-person care.[165] Even with this program,

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[162] *See* Eleri Jones et al., *Interventions to Provide Culturally-Appropriate Maternity Care Services: Factors Affecting Implementation,* BMC PREGNANCY CHILDBIRTH 2 (2017).

[163] *See Accountable Communities of Health (ACHs)*, WASH. STATE HEALTH CARE AUTH., https://www.hca.wa.gov/about-hca/medicaid-transformation-project-mtp/accountable-communities-health-achs [https://perma.cc/EQ7C-2A6H]; WASH. STATE HEALTH CARE INNOVATION PLAN, WASH. STATE HEALTH CARE AUTH. 19 (2014).

[164] HEALTHIER WASHINGTON: BETTER HEALTH, BETTER CARE, LOWER COSTS, WASH. STATE HEALTH CARE AUTH. 1 (2014) (healthier Washington is a program created to redesign the health care system in the state to create healthier citizens at lower costs) [hereinafter *Healthier Washington*].

[165] *See generally id.* at VII.

regulations have yet to be created.[166] Therefore, the new regulation should read as follows:

1. Accountable Communities of Health (ACH)
    a. Over the next four years, Washington State shall encompass ACH regarding maternal health. Specifically, links for coordination and integration must be created between those stationed within the communities and those stationed inside of hospital administration.
        i. The two sectors shall meet every quarter to discuss progress in maternal health and changes that must be implemented to reach the goals.
        ii. The two sectors shall meet once a year to create realistic goals for the year.

To build a sustainable healthcare system that does not discriminate based upon race, we must include social determinants of health into these programs. Programs must integrate tangible items, such as stable housing, access to nutritious food, and economic stability, into their model.[167] While ACH sectors can be an effective strategy to structure relationships and coordinate funding, they may also take many years to show progress.[168] Many federal government funding programs require progress to be shown

[166] *See generally id.* at 9.
[167] Jeffrey Levi et al., *Developing a Common Framework For Assessing Accountable Communities For Health,* HEALTH AFFAIRS (Oct. 24, 2018), https://www.healthaffairs.org/do/10.1377/hblog20181023.892541/full/ [https://perma.cc/L2ZT-6WBV].
[168] Marie Mongeon et al., *Elements of Accountable Communities for Health: A Review of the Literature,* NAT'L ACAD. OF MED. 4–5 (2017).

in three years.[169] However, it may take much more time to show an uptick in health outcomes.[170]

ACH sectors indicate progress towards improving health outcomes for pregnant women of color. Combatting public health and societal factors through these programs will only continue to improve the outcomes. ACH sectors ensure that mothers are receiving the care they need to guarantee that their own health is safe as well as the health of their babies. However, ACH sectors must put more of an emphasis on maternal health in Washington.

Every five years, the Washington DOH evaluates maternal health needs.[171] The state's block grant funding is impacted by these evaluations, and they use these evaluations to determine funding for specific measures.[172] The next grant cycle began on October 1, 2020, and will continue through September 30, 2025.[173] The grant cycle includes five national performance measures: (1) women's/maternal health; (2) infant/perinatal health; (3) child health; (4) adolescent health; and (5) children with special healthcare needs.[174] Notably, none of these measures include social determinants of health.[175]

To improve the health of our mothers, we must include social determinants in strategies to gain funding. Although the measures identified by the Washington DOH are important, the state should be focusing on affordable housing, poverty, and access to nutritious food. The Legislature's failure to include these measures directly and negatively

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[169] *Id.* at 4.
[170] *Id.*
[171] *Maternal and Child Health Block Grant*, WASH. STATE DEP'T OF HEALTH 67 (Aug. 26, 2021).
[172] *Id.* at 9.
[173] *Id.* at 194.
[174] *See generally id.*
[175] *See generally id.*

impacts a person's health.[176] Therefore, if a state focuses on improving these fundamental needs, then there will be measurable improvements in the health of women and mothers, infants, children, adolescents, and children with special healthcare needs.[177] Including social determinants of health into these already existing programs, or creating programs specifically aimed towards social determinants of health, is a crucial step Washington State must take in order to increase maternal health.

Additionally, in June of 2014, the Washington State Legislature set up funding through the State Innovation Models Round 2 test grant and supportive state legislation.[178] This funding was originally $485,000 in grants to ten different communities across the state.[179] This money and ACH designation and implementation was supposed to take place over the next four years.[180] However, Healthier Washington and the Senate Bill[181] do not encompass maternal health and the implications of mental health on maternal outcomes.[182] Therefore, the Washington Legislature must amend the final bill to include ACH for maternal health. The amended bill's section regarding maternal health should state the following:

> The Adult Behavioral Health Task Force (taskforce), which is intended to examine and reform the adult behavioral health system, must encompass mental health within maternal health. The taskforce will take 15% of the $1 million grant to assess this

[176] *See* FOOD RESEARCH & ACTION CTR., IMPACT OF POVERTY, FOOD INSECURITY, AND POOR NUTRITION ON HEALTH AND WELL-BEING 2, 3 (2017).
[177] *See* CTRS. FOR DISEASE CONTROL & PREVENTION, TEN ESSENTIAL PUBLIC HEALTH SERVICES AND HOW THEY CAN INCLUDE ADDRESSING SOCIAL DETERMINANTS OF HEALTH INEQUITIES 1 (2020), https://www.cdc.gov/publichealthgateway/publichealthservices/pdf/ten_essential_services_and_sdoh.pdf [https://perma.cc/25H8-UVKL].
[178] *Healthier Washington*, *supra* note 164, at 21.
[179] *Id.*
[180] *Id.*
[181] S.B. Rep. 6312, 63rd Leg., Reg. Sess. (Wash. 2014).
[182] *Healthier Washington*, *supra* note 164, at 21.

> mental health crisis and will come up with equitable solutions in an attempt to decrease maternal mortality due to mental health.[183]

This addition to the bill would increase accessibility to mental health resources for women who are experiencing mental illness post childbirth. Amending this bill and creating regulations are an integral part of the holistic approach of improving the health and wellness of the community and saving lives.

C. Extending Medicaid Through the First Year of Your Child's Life and the Fourth Trimester

The duration of pregnancy is divided into three trimesters which coincide with different stages of the baby's development leading up to birth. The first trimester, occurring between zero and thirteen weeks of gestation, is crucial for the baby's development because the baby is developing their body structure and organ systems.[184] Gestation is the process of carrying or being carried in the womb between conception and birth.[185] The second trimester is considered to be the "golden period" because this is the time where many of the unpleasant effects of pregnancy disappear.[186] This trimester occurs between fourteen and twenty-six weeks of gestation.[187] The third trimester is the last stretch of pregnancy before the mother welcomes her new baby, and occurs between twenty-seven and forty weeks of gestation.[188] But what happens after the baby is born?

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[183] *See id.*
[184] *Pregnancy: the three trimesters,* UCSF HEALTH, https://www.ucsfhealth.org/conditions/pregnancy/trimesters#:~:text=tired%20and%20emotional.-,Second%20Trimester%20(14%20to%2026%20Weeks),and%20an%20increased%20energy%20level [https://perma.cc/9CTU-NHBR].
[185] *Id.*
[186] *Id.*
[187] *Id.*
[188] *Id.* at 42.

The period of time following pregnancy, recently dubbed the fourth trimester, is a critical time for the mother's development as she learns how to care for her infant and her own biological changes.[189] During the fourth trimester, mothers are bonding with their babies and adjusting to a world with a new person in it.[190] Additionally, mothers often experience postpartum pain, breastfeeding challenges, and a wide range of fluctuating hormones.[191] This time in an individual's life comes with emotional and physical tolls; in one moment, a new mother could be elated and proud, and in the next moment, a mother could be questioning her ability to care for and raise a child.[192] Although Medicaid only covers new mothers for sixty days after the end of the pregnancy, it extends eligibility for Family Planning.[193] This coverage is automatic and includes all forms of birth control, permanent methods to stop having children, and doctor's visits related to receiving birth control.[194] However, benefits do not continue past ten months after the pregnancy has ended, whether that be by birth, miscarriage, or abortion.[195] What is not included in family planning is mental health counseling, which is important during this time when the mother's hormones fluctuate and postpartum depression is common.[196] These effects of pregnancy make women susceptible to mental health and substance abuse conditions.[197]

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[189] Lauren Barth, *What's With the 4th Trimester? Adjusting to Life with a Newborn*, HEALTHLINE (May 9, 2020), https://www.healthline.com/health/pregnancy/4th-trimester [https://perma.cc/QA2B-R569].
[190] *Id.*
[191] *Id.*
[192] *Id.*
[193] *Pregnant Individuals*, *supra* note 129.
[194] *See id.*
[195] *See id.*
[196] Nancy Hamilton et al., *The Fourth Trimester: Toward Improved Postpartum Health and Healthcare of Mothers and Their Families in the United States,* J. BEHAV. MED. 573 (Oct. 2018).
[197] MATERNAL MORTALITY REVIEW PANEL, *supra* note 61, at 22.

Hospitals that care for a higher proportion of Black individuals have worse health outcomes than other hospitals, suggesting that there are systemic issues among hospitals that require targeted interventions.[198] Lenny López and Ashish K. Jha conducted a study that used 2007 Medicaid statistics to calculate thirty- and ninety-day mortality rates among white and Black patients.[199] This study analyzed healthcare outcomes for Black and white individuals who were admitted to the hospital for acute myocardial infarction (heart attack), congestive heart failure, or pneumonia, and were insured under Medicaid.[200] The study ranked all the hospitals in the country by the proportion of discharged Black patients, and then took the top ten percent of these hospitals as "Black serving."[201] The study showed that hospitals that cared for a large proportion of Black patients generally had comparable mortality rates; however, this was due in part to the fact that Black patients had generally lower thirty-day mortality rates.[202] On the other hand, when comparing ninety-day mortality rates, Black patients have higher rates for heart attacks and pneumonia than white patients.[203] Many of the Black-serving hospitals were teaching hospitals which were commonly known for delivering high quality care.[204]

This race-specific analysis provides insights into why Black-serving hospitals have worse outcomes than their white counterparts. Generally, Black patients have greater barriers than white patients when it comes to healthcare: they have a lower life expectancy, they receive lower intensity treatments, and they are often sicker at the time of admission than white

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[198] Lenny López & Ashish K. Jha, *Outcomes for Whites and Blacks at Hospitals that Disproportionately Care for Black Medicare Beneficiaries*, 48 HEALTH SERVS. RSCH. 114, 121 (Feb. 2013).
[199] *Id.*
[200] *Id.*
[201] *Id.*
[202] *Id.* at 122.
[203] *Id.*
[204] *Id.*

patients.[205] Looking at mortality rates of hospitals can be misleading when based upon proportions of white patients versus Black patients that make up these rates.[206] Lastly, the study found that the gap tended to widen between Black-serving hospitals and non-Black-serving hospitals over time.[207] This gap suggests that outpatient care associated with Black-serving hospitals may be less effective; however, there must be further research into these outpatient treatments to better understand why.[208]

Although this study does not analyze pregnant women specifically, it does give us insight into how Black people are treated in healthcare settings. The United States is one of thirteen countries worldwide that has a rising maternal mortality ratio; of these thirteen countries, the U.S. is the only one with an "advanced economy."[209] As seen in the Lenny López et al. survey, these poor health outcomes are not inevitable.[210] The outcomes are instead based on policies, laws, and institutional practices that can and should be changed.[211] Women who live in states where Medicaid has not expanded have their Medicaid revoked after sixty days postpartum and although they are significantly low income, their incomes are still too high to qualify for Medicaid.[212] Extending parental Medicaid through the first year of a child's life will save lives, both in hospitals and during the postpartum period.

IV. CRITIQUES ON PROPOSED CHANGES

There are two major critiques for amending the RCW and one for expanding Medicare for new parents throughout the first year of a baby's

[205] *Id.* at 123.
[206] *Id.*
[207] *Id.* at 124.
[208] *Id.*
[209] *Black Mamas Matter, supra* note 41, at 9.
[210] *Id.* at 10.
[211] *Id.*
[212] Ranji et al., *supra* note 140.

life. First, amending statutes and enacting new legislation takes time.[213] Second, critics of these amendments argue that these educational trainings tend to be taught in a reductionist way,[214] while the critics of expanding Medicaid will argue that these programs will be expensive for taxpayers and will put the government into an increased amount of debt.[215]

A. Deficiency in Enacting New Legislation

Critics argue that expanding Medicaid to include this programming will be a costly investment that is likely to get passed onto the states and increase taxes.[216] They argue that there are too many able-bodied people enrolling in the program, government spending had doubled between 2000 and 2016, and that Medicaid expansion would cost seventy-six percent more than original estimates.[217] Critics argue that Medicaid should not be expanded and that those states that have expanded Medicaid should work to roll it back.[218]

While these concerns may be valid, they are mostly unfounded in the research done between 2013 and 2017.[219] States that have expanded Medicaid have a much lower uninsured rate than states that have not—that

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[213] *See* CHRISTOPHER M. DAVIS, CONG. L. RSCH. SERV., THE AMENDING PROCESS IN THE SENATE 1 (Mar. 15, 2013), https://digital.library.unt.edu/ark:/67531/metadc287915/m1/1/high_res_d/98-853_2013Mar15.pdf [https://perma.cc/9NCH-99KK].

[214] Jennifer Tsai, *A Critique of Cultural Competency in Health Care,* IN-TRAINING: IN AGORA OF THE MEDICAL STUDENT COMMUNITY (Jan. 31, 2016), https://in-training.org/critique-cultural-competency-10456 [https://perma.cc/F7WD-P773].

[215] Jesse Cross-Call, *Medicaid Expansion Continues to Benefit State Budget, Contrary to Critics' Claim,* CTR. ON BUDGET AND POL'Y PRIORITY (Oct. 9, 2018), https://www.cbpp.org/research/health/medicaid-expansion-continues-to-benefit-state-budgets-contrary-to-critics-claims [https://perma.cc/3GGR-LFXP].

[216] Jonathan Ingram & Nic Horton, *A Budget Crisis in Three Parts: How ObamaCare is Bankrupting Taxpayers,* THE FOUND. FOR GOV'T ACCOUNTABILITY 4 (Feb. 1, 2018), https://thefga.org/paper/budget-crisis-three-parts-obamacare-bankrupting-taxpayers/ [https://perma.cc/9XVK-24DM].

[217] *Id.* at 2.

[218] *Id.* at 11.

[219] Cross-Call, *supra* note 215.

gap continues to grow.[220] Medicaid enrollment and costs have stabilized after initial growth in 2014, showing 8.8% in 2014 and only 3.1% in 2016.[221] Additionally, there is evidence that Medicaid expansion saves states money in the long run.[222] From 2014–2016, the federal government paid one hundred percent of the cost under the ACA, and they are projected to only pay ninety percent in 2020.[223] By comparison, the federal government pays between fifty and seventy-six percent of the cost of other Medicaid enrollees.[224] Although this is a concern that the government should be analyzing, it is not as large of a detriment to a state budget as originally thought.

Amending bills takes a lot of time and it is not something that happens overnight. To consider amending a bill, the Senate or the houses of the Legislature reads the title of the measure and then begins to debate whether this amendment will help or hinder the legislation.[225] There are three ways to propose amending an existing law: (1) insert new text; (2) strike text in the existing law; and (3) strike text and insert new text in its place.[226] These debates begin with opening statements on the bill as a whole and then move into each Senator offering their own opinions on amendments to that section of the bill.[227] The first amendments that are considered are those recommended by the committees that report to that measure.[228] The Senate then proposes amendments for each recommendation and provides a single text to include all of its recommendations.[229] Occasionally, amendments

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[220] *Id.*
[221] *Id.*
[222] *Id.*
[223] *Id.*
[224] *Id.*
[225] DAVIS, *supra* note 213.
[226] RICHARD S. BETH, CONG. RSCH. SERV., REPORT FOR CONGRESS: HOW BILLS AMEND STATUTES 1 (Aug. 4, 2003), https://sgp.fas.org/crs/misc/RS20617.pdf [https://perma.cc/RA56-B5MQ].
[227] DAVIS, *supra* note 213.
[228] *Id.*
[229] *Id.* at 2.

presented by a committee are excluded from this text; this leaves the amendment open for debate and to be considered separately.[230] Next, the Senate considers first-degree amendments[231] in whatever order it sees fit. This continues through second and third-degree amendments, although third-degree amendments are extremely rare and are only allowed by unanimous consent.[232] This is a multi-step process that may take months, if not years, from start to finish.

Although the time it takes to amend a bill is long, it is an important piece of our government. Amending legislation can be used to read specific text in a specific way, create new provisions to maintain the desired reading, and maintain our state laws up to date with the changes in society and politics.[233] Amending legislation is something that dates back at least to the eighteenth century, when the First Amendment to the U.S. Constitution was adopted.[234] Amending legislation is not something that is new to our country, nor our state, and should not be used as a reason to not push new legislation in order to increase cultural competency in healthcare.

B. Educational Trainings Taught in a Reductionist Way

The argument against continued education in cultural competency is that the programs have a tendency to be taught in a way that oversimplifies the issues and the solutions.[235] This is typically referred to as teaching in a reductionist way, which is defined as "a person who analyzes and describes a complex phenomenon in terms of its simple and fundamental

[230] *Id.*
[231] *Id.* at 5.
[232] *Id.* A second-degree amendment proposes to change the text of a first-degree amendment that the Senate is considering. A third-degree amendment is an amendment to change the amendment of an amendment.
[233] BETH, *supra* note 226, at 2.
[234] U.S. Const. amend. I (1791).
[235] Tsai, *supra* note 214.

constituents."[236] The arguments tend to revolve around cultural competency education courses that use PowerPoint slides with assumptions about other cultures and customs that fall into a category of "X group of patients think, talk, believe, eat, and feel like Y."[237] Although there is no explicit harm that comes from understanding a culture's background, the harm comes when assumptions are made about a specific culture, race, and background.[238]

These are very real concerns that should be addressed. Educational programs must appreciate that all people do not eat, think, and believe the same things. The appreciation for diverse perspectives and ways of life needs to be reflected in the way these educational programs teach healthcare professionals. However, they may eat, think, and believe differently than the doctor may think that they should. This simply is not the case. These programs should not put patients in a box based upon their race, culture, and ethnicity; instead, they should educate healthcare professionals based upon real-life experiences of racial and ethnic minority groups.[239] Individuals who teach these classes must go through extensive training to completely understand the experiences these groups face in the healthcare sector. The teachers should speak to individuals and families who have lived through these experiences so that they can better understand, and then teach, based on real experiences.

V. CONCLUSION

Every woman has the right to safely bring a baby into this world. Yet Black women are dying every day from preventable healthcare mistakes

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[236] *Reductionist*, DICTIONARY.COM (2020), https://www.dictionary.com/browse/reductionist [https://perma.cc/2UQP-EULV].
[237] Tsai, *supra* note 214.
[238] *Id.*
[239] A TREATMENT IMPROVING PROTOCOL: IMPROVING CULTURAL COMPETENCE, SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN. 9 (2014), https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4849.pdf [https://perma.cc/VZ5K-VPNW].

made during childbirth.[240] Despite governmental obligations to prevent maternal mortality, it has become one of the most underreported civil rights violations of our time.[241] Women like Kira Johnson and millions of others are falling victim to the healthcare system in America, and their children are growing up without mothers because of it.[242] It is clear that something needs to be done to combat maternal mortality, and it must be done now.

Washington has taken steps towards combatting maternal mortality, such as the enactment of RCW 43.70.615. The Washington State Legislature should take this statute one step further by amending it to require continuous education after becoming a healthcare provider. Requiring a specific number of hours to be dedicated to continued education will remind healthcare providers about implicit biases, help them find where their own bias lies, and can and will save the lives of women and their children in childbirth.[243] Additionally, Washington has already implemented ACHs into its public health systems. However, the Washington DOH should increase funding to these sectors and add social determinants of health to the maternal health sector to increase maternal health in Washington and decrease maternal mortality.[244]

Washington State must also expand Medicaid insurance coverage for the mother through the first year of the child's life. This period is when new mothers may develop mental health disorders, such as postpartum depression,[245] which can be screened for during trips to the doctor after the child is born.[246] Expanding Medicaid past sixty days after a child is born

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[240] *Black Mamas Matter, supra* note 41, at 10.
[241] *Id.* at 9.
[242] Helm, *supra* note 10.
[243] *See generally* Irene V. Blair et al., *Unconscious (Implicit) Bias and Health Disparities: Where Do we Go From Here?,* PERMANENTE J. 73 (2011).
[244] MATERNAL MORTALITY REVIEW PANEL, *supra* note 61, at 67.
[245] Yvette Brazier, *How Long Does Postpartum Depression Last?*, MED. NEWS TODAY (Nov. 2019), https://www.medicalnewstoday.com/articles/271217 [https://perma.cc/MQN9-W875].
[246] *Id.*

will save the lives of mothers and children who cannot afford private medical insurance. Research shows that Black patients have worse health outcomes on average than white patients,[247] so we must work towards changing the way the system looks at Black people in the healthcare sector. These women do not deserve to die bringing a new child into this world, and these children do not deserve to grow up without a mother. It is time to put action behind our words and work towards equity within healthcare.

[247] López & Jha, *supra* note 198, at 123.