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I. Policy Recommendations

This chapter details policy proposals to address harms set forth in Chapter 12, Mental and Physical Harm and Neglect.

- Address Health Inequities Among African American Californians by Funding the California Health Equity and Racial Justice Fund
- Improve Health Insurance Coverage
- Evaluate the Efficacy of Health Care Laws, Including Recent Enactments
- Address Anti-Black Discrimination in Health Care
- Mandate Standardized Data Collection
- Provide Medical Social Workers/Health Care Advocates
- Improve Diversity Among Clinical Trial Participants
- Remedy the Higher Rates of Injury and Death Among African American Mothers and Infants
- Fund Community Wellness Centers in African American Communities (See Chapter 20 for the text of this recommendation.)
- Fund Research to Study the Mental Health Issues Within California's African American Youth Population, and Address Rising Suicide Rates Among African American Youth (See Chapter 20 for the text of this recommendation.)
- Meet the Health Needs of African American Elders
- Remedy Disparities in Oral Health Care
- Address Disparities and Discrimination Associated with Substance Use Recovery Services (See Chapter 25 for the text of this recommendation.)
- Fix Racially Biased Algorithms and Medical Artificial Intelligence in Health Care
- Fund and Expand the UC PRIME-LEAD-ABC Program to be Available at All UC Medical Campuses

- Create and Fund Equivalents to the UC-PRIME-LEAD-ABC Program for Psychologists, Licensed Professional Counselors, and Licensed Professional Therapists
- Permanently Fund the California Medicine Scholars Program and Create and Fund Equivalent Pathway Programs for Students in the CSU and UC Systems
- Review and Prevent Racially Biased Disciplinary Practices by the Medical Board of California

- Address Food Injustice

- Increase Greenspace Access and Recreation Opportunities in African American Communities (See Chapter 24 for the text of this recommendation.)

Unequal health outcomes “cannot be explained away by factors like age, income, or education level” — through implicit biases and racism, the health care system treats Black Californians differently.

- Test for and Eliminate Toxicity in Descendant Communities (See Chapter 24 for the text of this recommendation.)
- Increase Trees in Redlined and Descendant Communities (See Chapter 24 for the text of this recommendation.)
- Develop Climate Resilience Hubs in Redlined and Descendant Communities (See Chapter 24 for the text of this recommendation.)
- Remove Lead in Drinking Water (See Chapter 24 for the text of this recommendation.)
- Prevent Highway Expansion and Mitigate Transportation Pollution (See Chapter 24 for the text of this recommendation.)

Address Health Inequities Among African American Californians by Funding the California Health Equity and Racial Justice Fund

As set forth in Chapter 12, Mental and Physical Harm and Neglect, due to discrimination, disempowerment, and neglect of African American patients by healthcare institutions, African American communities have suffered major gaps in healthcare delivery.¹ The impact can be seen in virtually every aspect of physical and mental health outcomes. “African Americans have higher rates of morbidity and mortality than white Americans for almost all health outcomes in the United States, an inequality that increases with age.”² This is connected to African Americans suffering from weathering, or “constant stress from chronic exposure to social and

economic disadvantage, which leads to accelerated decline in physical health.”³ Unequal health outcomes “cannot be explained away by factors like age, income, or education level” — through implicit biases and racism, the health care system treats Black Californians differently.⁴

Numerous articles and studies have documented the necessity of remedying the poor health outcomes among African Americans through reparations.⁵ Social determinants of health—such as household income, neighborhood

wealth, education, and health insurance—explain about half of racial health disparities in life expectancy.⁶ One report focused on social determinants of health observed that “studies suggest that health behaviors, such as smoking, diet, and exercise, and social and economic factors are the primary drivers of health outcomes,” and, thus, addressing social determinants of health is important “for reducing health disparities that are often rooted in social and economic disadvantages.”⁷ But social determinants of health can be improved. An American Public Health Association report has found that community-based organizations “amplify community concerns and, in coordination with public health departments, contribute to more effective policy solutions.”⁸

The Task Force recommends authorization and ongoing funding for the proposed California Health Equity and Racial Justice Fund⁹ within the California Department of Public Health’s Office of Health Equity. The Office of Health Equity would administer an annual \$115 million grant program, with appropriate year-to-year increases, to address health disparities focusing on social determinants of health. Clinics and community-based organizations (CBOs) could apply for grants, either separately or in collaboration. Applicants would be required to demonstrate how funding would be used to ameliorate existing or emerging health disparities and include metrics for success. Local health jurisdictions would be encouraged to work with grant recipients to serve as trusted community partners to extend public health messages and interventions to underserved and difficult-to-reach communities. This recommendation incorporates a provision from Assembly Bill (AB) 1038¹⁰ to authorize a California Health Equity and Racial Justice Fund Oversight and Accountability Committee to monitor the distribution, implementation, and impact

of local and regional grants funded by the California Health Equity and Racial Justice Fund.

Nearly 200 nonprofit advocacy and provider organizations have urged that funding be prioritized for the California Health Equity and Racial Justice Fund, which also has the support of members of the California State Legislature.¹¹ Health clinics, tribal organizations, and other community groups contend that funding in the form of state grants from the Health Equity and Racial Justice Fund will benefit the communities that need the most help.¹² The Task Force agrees and urges that the Fund be established and resourced, with a specific focus and mandate to include addressing health disparities suffered by African Americans, with special consideration for descendants.

Improve Health Insurance Coverage

The California Health Care Foundation reports that, although Black Californians have higher health insurance coverage rates than the state average, “structural barriers in the health care system prevent them from achieving the health they actively seek.”¹³ Moreover, a disproportionately high percentage of African American Californians rely on Medi-Cal. Medi-Cal provided coverage for 28 percent of Black Californians in 2019 (compared to 10 percent of white Californians).¹⁴ Adults enrolled in Medi-Cal were more than twice as likely to report difficulty finding a provider that accepted their insurance as compared to those with employer-based insurance or Medicare, and this was the case for both primary and specialty care.¹⁵ At least some experts have identified low reimbursement rates for providers who accept Medi-Cal as a racial justice issue.¹⁶

The Task Force recommends closing the health coverage gaps through the adoption of a comprehensive universal single-payer health care coverage and health care cost control system for the benefit of all African Americans in California, with special consideration for those who are descendants. For the many African Americans in California who remain on Medi-Cal, the Task Force also recommends increases to the Medi-Cal reimbursement rates to achieve parity with the reimbursement rates of private insurance.

Experts have identified low reimbursement rates for providers who accept Medi-Cal as a racial justice issue.

Evaluate the Efficacy of Health Care Laws, Including Recent Enactments

As established in Chapter 12, Mental and Physical Harm and Neglect, health care systems and institutions have systematically discriminated against and provided

substandard care to African Americans, resulting in grave health disparities.¹⁷ Over the 2021-2022 Regular Session of the California State Legislature, a variety of bills were introduced in an effort to improve access to health care.¹⁸ Some of the measures that were adopted included: Senate Bill (SB) 838, to further the efforts of the California Health and Human Services Agency to create a California-branded label for generic drugs to increase patient access to affordable drugs and lower health care costs; SB 644, requiring the Employment Development Department to share information with Covered California for outreach to persons applying for or losing unemployment benefits to enroll them in Covered California or Medi-Cal; and SB 1019, requiring Medi-Cal plans to conduct annual outreach and education to members and primary care physicians regarding the plan’s mental health benefits.¹⁹

Further, Governor Newsom’s 2022-2023 budget included a notable increase in spending on health programs, many of which were aimed at remedying issues of cost.²⁰ Among other aspects, the budget included trailer legislation to formally establish the Office of Health Care Affordability within the Department of Health Care Access and Information.²¹

However, despite persistent health inequality, there is currently no office within the California Health and Human Services Agency (the parent agency to the California Department of Health Care Services, California Department of Public Health, and a number of other health-related agencies) that is specifically tasked with evaluating whether recent efforts have improved health disparities among African Americans.

To address entrenched health disparities, the Task Force recommends mandating that the California Department of Public Health’s Office of Health Equity conduct an annual review of California health care laws and policies, evaluate their effect on reducing health disparities among African Americans, and publish its findings and recommendations to the California State Legislature. These

recommendations should explicitly include how to design and implement consequences for health care providers who do not address and reduce identified treatment disparities. This measure would include funding on an annual basis to hire permanent staff dedicated to these

efforts, based on the Office of Health Equity’s assessment of the level of staffing needed. This proposal builds on Senate Concurrent Resolution No. 17, which was chaptered on April 30, 2021, and states that “the Legislature

declares racism to be a public health crisis and will actively participate in the dismantling of racism . . .”²²

Address Anti-Black Discrimination in Health Care

Racial disparities in Black health outcomes are a result of historical racial inequality, discriminatory health policy, and persistent racial discrimination across different aspects of life in the United States.²³ African Americans receive fewer procedures and poorer-quality medical care across almost every type of diagnostic and treatment intervention than do white Americans.²⁴ As stated previously, African Americans have higher rates of morbidity and mortality than white Americans in almost all health outcomes, and this inequality only increases with age.²⁵ Fortunately, evidence suggests that these trends and health harms arising out of implicit and explicit bias may be remedied through concerted effort.²⁶

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Relatedly, the Association of American Medical Colleges (the administrator of the Medical College Admission Test (MCAT)) has expressed interest in testing students on situations that involve implicit bias.²⁷

To address discrimination against African Americans in health care, the Task Force recommends the Legislature add the completion of an evidence-based anti-bias training and an assessment based on such training to the graduation requirements of all medical schools and any other medical care provider programs in California receiving state funding and not already covered, including mental health professional programs (psychologists, Ph.D., or Psy.D.), masters-level programs in psychology or therapy (for counselors, clinicians, and therapists), and programs for clinical social workers.

Mandate Standardized Data Collection

Dr. Mary T. Bassett, the New York State Health Commissioner and Professor of the Practice of Health and Human Rights at the Harvard T.H. Chan School of Public Health, writes that “[l]ong-standing racist government policies—from housing to health care, employment to a flawed legal system—that have systematically deprived Black Americans of equal rights, opportunities, wealth, and resources” account for the

reasons Black Americans have poorer health and lower life expectancy.²⁸ In addition to acknowledging medicine and public health’s role in perpetuating racism and participating in local, state, and national conversations around reparations, Dr. Bassett advocates for using health outcomes captured in public health data as a key measure of equity.²⁹ She notes that “[s]uccessful reparations means eliminating racial health disparities” and that “[u]ntil racism no longer drives negative effects on the health and length of a Black person’s life, equity remains theoretical.”³⁰ A number of experts in the field also recommend improved data collection in order to advance equity in health care and health outcomes.³¹

The Task Force recommends the creation of statewide standards for data collection and reporting of demographic and social needs data in order to reduce health disparities and address social drivers and determinants of health.³² This proposal could build off of Senate Bill (SB) 1033, which would have required the California Department of Managed Health Care to develop and adopt regulations establishing demographic data collection standards and require health care service plans and health insurers to assess “the individual cultural, linguistic, and health-related social needs of enrollees and insureds for the purpose of identifying and addressing health disparities, improving health care quality and outcomes, and addressing population health.”³³

Provide Medical Social Workers/Health Care Advocates

A study completed by the California Health Care Foundation revealed the majority of Black Californians devote “a great deal/quite a bit of effort to their health” and agree on many suggestions to address racism in health care.³⁴ Black Californians agree that one way to remedy racism in health care is to expand community-based resources.³⁵ Specifically, 84 percent of respondents believe it is extremely important or very important to expand community-based education on how to navigate the healthcare system and advocate for high quality care.³⁶ And 77 percent of respondents believe it is extremely important or very important to expand the number of Black community health advocates and/or medical chaperones available to patients.³⁷

The Task Force recommends the Legislature provide funding to ensure that medical social workers/health care advocates are available to serve as advocates, chaperones, and third party observers when requested to

address African Americans' concerns and experiences of bias and other disparate treatment in the delivery of medical care and mental and behavioral health services. These medical social workers and health care advocates would be required to undergo implicit bias training and demonstrate cultural congruence with the community to be served.³⁸ They preferably would be situated within trusted community-based organizations, which may be achieved through a state-funded grant-making program.

Improve Diversity Among Clinical Trial Participants

Among clinical trial participants in the United States, African American patients comprise only five percent while white patients comprise the vast majority.³⁹ Explanations for these statistics include historical exploitation and racism—atrocities such as the Tuskegee Syphilis Study used unethical research practices and caused unnecessary harm, deception, and biomedical exploitation of African Americans.⁴⁰

Clyde Yancy, MD, vice dean for diversity and inclusion at Northwestern University Feinberg School of Medicine, has noted that not all humans are the same physiologically, and factors such as age, illnesses, and genetic ancestry may result in drugs being metabolized differently or responding to devices differently.⁴¹ When trial participation is not reflective of the general population, pharmaceutical companies and medical professionals do not know how various drugs will work in different populations.⁴² For example, albuterol, a drug used to treat asthma, was found to have decreased effectiveness in African American children.⁴³ Dr. Yancy has stated that clinical trial study designs should be intentional from the very beginning about being inclusive, especially when members of a certain group might benefit from being studied due to a prevalence of a disease in their group.⁴⁴ Dr. Yancy also noted that governments should issue requirements for recruitment targets and provide incentives such as rewarding those who succeed with more funds or grant opportunities.⁴⁵

Researchers have begun to institute changes to remedy lack of inclusion and representation in clinical trials, such as “bringing trial procedures closer to where participants live, diversifying the staff who recruit people for the studies, and designing trials to directly target underrepresented groups.”⁴⁶ A primary barrier to participation is getting to the central site for “assessments, administration of therapies, tests to monitor results, and medications to take home”; these locations can involve several hours per trip and paying for transportation and food.⁴⁷ To remove this barrier, some of the procedures

can be carried out at medical offices and clinics in communities where African Americans live.⁴⁸

Dr. Airin D. Martínez, assistant professor in Health Policy and Management at the University of Massachusetts-Amherst, has noted that there are a lack of principal investigators from marginalized racial or ethnic groups, which may also be a factor in the underrepresentation of African Americans in clinical trials.⁴⁹ She has emphasized that representation on the side of scientists as much as on the side of research participants matters, as they “bring different perspectives to the research informed by both [their] scientific training and [their] lived experiences.”⁵⁰

Another barrier to participation is not seeing African Americans among recruiters and the staff who are explaining the trial.⁵¹ The CARE Research Center, which runs trials and consults on increasing diversity in trials, advises researchers to diversify the staff working on studies, especially those who interact most with possible participants.⁵² Other proposed solutions include: aiming for a proportion of African American participation similar to their proportion in disease incidence cases; providing financial support for study participants to cover indirect expenses such as time off from work, childcare, and transportation; requiring funding agencies to include race and ethnicity for assigning pri-

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A woman receives an injection during a clinical trial for a Covid -19 vaccine. (c.2020)

ority scores (as the final score typically determines grant funding and will lead to researchers actively trying to recruit African Americans); and targeting enrollment in a culturally sensitive manner.⁵³

To remedy this issue, the Task Force recommends funding competitive grants for clinical trials to subsidize participants' indirect costs (such as time off from work, transportation, and childcare), undertake and complete clinical trials in communities where African Americans

live, and hire staff demonstrating cultural congruence with the African American community to serve as recruiters and staff explaining clinical trials. The Task Force also recommends providing extra funding and other incentives for state-funded studies in which the principal investigators are African American.

Remedy the Higher Rates of Injury and Death Among African American Mothers and Infants

As established in Chapter 12, Mental and Physical Harm and Neglect:

One of the most harmful legacies of slavery is the disproportionate maternal and infant death of African American women and children today due to lack of access to adequate reproductive healthcare. African American women experience disproportionate racial discrimination in access to and quality of prenatal care. Expecting and new African American mothers often find that their reports of painful symptoms are overlooked or minimized by medical practitioners. . . . African American women disproportionately experience adverse birth outcomes and adverse maternal health. Researchers have found evidence that this may be influenced by the uniquely high level of racism-induced stress experienced by African American women . . .⁵⁴

African American mothers in California are substantially more likely than white mothers to suffer severe health complications during their pregnancy, give birth prematurely, die in childbirth, and lose their babies.⁵⁵ The pregnancy-related mortality ratio for Black women during 2014 to 2016 was four to six times greater than the mortality ratio for any other ethnic group.⁵⁶ “Over the past decade, Black babies died at almost five times the rate of white babies in San Francisco.”⁵⁷ Further, Black women in California disproportionately experience unfair treatment, harsh language, and rough handling during their hospital stay, compared to white mothers.⁵⁸

Further, according to a recent study at the University of Texas at San Antonio: “During and after pregnancy, Black women . . . faced heightened odds of death that were almost double those of white women, along with a risk of dying specifically from pregnancy complications that was 2.8 times that of white women. . . . But more than any other racial or ethnic group, Black women died as a result of homicide; they were five times more likely to be killed this way than white women.”⁵⁹

Another recent study published by the National Bureau of Economic Research found “[t]he richest Black mothers and their babies are twice as likely to die as the richest white mothers and their babies,” suggesting that the racial gap in infant and maternal care is not just explained by differences in socioeconomic status, but rather that there is a structural problem.⁶⁰ The study further found that “babies born to the richest Black women (the top tenth of earners) tended to have more risk factors, including being born premature or underweight, than

From 2006-2014, compared to white infants, African American infants in San Francisco had a

5x **HIGHER** **infant mortality rate**

those born to the richest white mothers—and more than those born to the poorest white mothers.”⁶¹ With the support of doulas, women have been less likely to have C-sections and more likely to have healthier babies.⁶² With regard to bias, as the University of California, San Francisco’s California Preterm Birth Initiative has documented, “numerous studies have demonstrated that doulas can help reduce the impacts of racism on pregnant women of color by helping to provide culturally appropriate, patient-centered care.”⁶³

Despite the research showing its benefits, doula care has been under-utilized, often due to barriers like cost, coverage, and lack of information.⁶⁴ Having identified several barriers and implementation challenges related to Medicaid coverage for doula care, the Preterm Birth Initiative in partnership with the National Health Law Program offered a number of recommendations to bring about successful coverage of doula care, including: (1) setting a common set of criteria for doula qualification or credentialing for insurers to pay for doula services; (2) developing doula reimbursement rates based on the amount of one-on-one time spent with a patient; (3) streamlining and organizing payments for doula services; (4) pushing for doula services to be classified as preventive services; (5) increasing their flexibility to pay for doula services; and (6) allowing doulas to obtain payment directly from Medicaid.⁶⁵

Building on steps the state has taken to advance coverage for doula care, the Task Force recommends the California Department of Health Care Services (DHCS) provide additional support for doula services (which is a covered

benefit, effective January 1, 2023)⁶⁶ to include: requiring DHCS to develop multiple payment and billing options for doula care, and to ensure specified payment and billing practices, including that any doula and community-based doula group be guaranteed payment within 30 days of submitting any claim for reimbursement;⁶⁷ requiring DHCS to establish a centralized registry listing any doula who is available to take on new clients in each county; requiring each Medi-Cal managed care health plan in every county to provide information in its materials, and specified notices, on identified topics related to doula care, including reproductive and sexual health, and to inform pregnant and postpartum enrollees and prenatal and postpartum enrollees at appointments about doula care, such as the availability of doula care and how to obtain a doula; requiring DHCS to convene a doula advisory board that would be responsible for deciding on a list of core competencies required for doulas authorized by DHCS to be reimbursed under the Medi-Cal program; requiring doulas to provide documentation that they have met the core competencies specified by the board as a prerequisite to being reimbursed under the Medi-Cal program; requiring DHCS to work with outside entities, such as foundations, to make trainings that meet the core competencies available at no cost to people who are from communities experiencing the highest burden

descendants of an individual enslaved in the United States, who are interested in becoming doulas. This support should include full funding for credentialing. The Task Force also recommends fully funding care provided by doulas and midwives from conception to postpartum for African Americans, including free lactation education and education at every stage of pregnancy.

The Task Force further recommends the California Department of Public Health's Office of Health Equity or other appropriate entity conduct an annual review of California health care laws and policies (including the Medi-Cal expansion) related to improving health outcomes for the birthing population, including access to quality prenatal care. The review should evaluate the effect of these laws and policies on reducing health disparities among the African American birthing population and infants in California, and the findings and recommendations should be published to the California State Legislature. This measure would include funding on an annual basis to hire permanent staff dedicated to these efforts, based on the Office of Health Equity's assessment of the level of staffing needed.

The Task Force also recommends funding the Office of Health Equity to study all of the factors and causes that contribute to disparities in maternal and infant health outcomes among African Americans, including medical complications in pregnancy and childbirth, but also causes such as homicide and car accidents, and publish a report of findings and recommendations to the California State Legislature. This study shall include recommendations on how the state can remedy these disparities.

Finally, the Task Force recommends state funding to the California Department of Public Health to evaluate the effectiveness of the Black Infant Health Program⁶⁹ in reducing health disparities and mortality rates among African American infants and publish its findings and recommendations to the California

State Legislature. These findings and recommendations shall include recommendations on a permanent source of funding for this program, recommendations on how the state can expand the program, and evidence-based recommendations on how the state can further care for all African American infants and work toward reducing health disparities and mortality rates.



A pregnant African-American woman with her doula or birth support coach.

of birth disparities in the state; and providing funding to DHCS for data collection, reporting, and analysis to evaluate maternal health outcomes resulting from having doula care as a covered preventive service under the Medi-Cal program.⁶⁸

Relatedly, the Task Force recommends funding pipelines for African Americans, especially those who are

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Meet the Health Needs of African American Elders

While African American elders (60+) represent only six and one-half percent of California's older adult population, the State of California is home to one of the largest concentrations of African American elders in the nation.⁷⁰ As discussed in Chapter 12, Mental and Physical Harm and Neglect, African American elders face specific health challenges arising out of the systemic injustices endured by the community. Physicians widely hold racist beliefs that Black patients feel less pain or exaggerate their pain, leading to racial bias in pain treatment for chronic conditions.⁷¹ African American elders are less likely to have their chronic illnesses sufficiently managed, are more likely to die from such conditions than white Americans, and have a shorter life expectancy than white Americans.⁷²

Additionally, as discussed in Chapter 12, Mental and Physical Harm and Neglect, due to the low levels of employer-sponsored health coverage for African Americans and the expense of private insurance, African American elders are far more likely than white Americans to rely solely on the Medicare program, and lack of supplemental insurance exposes African American elders to higher out-of-pocket costs and delayed medical care.⁷³ Finally, as discussed in Chapter 7, Racism in Environment and Infrastructure, African American elders face disparity in access to high-speed internet access and technology, which the COVID-19 pandemic made a critical piece of the health delivery infrastructure.⁷⁴

The Task Force recommends a series of measures aimed at ameliorating African American elders' experience of systemic disparity in the areas of management of pain and chronic conditions creating disability, end of life care, public benefits, and digital health access.

African American elders are less likely to have their chronic illnesses sufficiently managed, are more likely to die from such conditions than white Americans, and have a shorter life expectancy than white Americans.

Remedy the Mismanagement of Pain and Chronic Conditions Creating Disability

Due to the systemic injustices discussed in Chapter 12, Mental and Physical Harm and Neglect, elder African American adults are less likely to have their chronic illness sufficiently managed, are more likely to die from chronic illnesses that are well controlled in white Americans, and continue to suffer from poorer health care outcomes

throughout their lifespan to end-of-life.⁷⁵ For example, risk of diabetes, heart disease, and stroke increase among Black adults as they age because of poor blood pressure control and poor diabetes prevention due to disparities in medical care.⁷⁶

Moreover, younger African Americans are being diagnosed with chronic diseases normally seen in older populations, and thus African Americans often experience significant symptom burden and higher risk of complications as they age in comparison to their white counterparts because they have lived longer with chronic disease.⁷⁷ This can intensify the suffering African American elders experience towards the end-of-life.⁷⁸

Additionally, African American elders are at increased risk of being undertreated for pain. Their pain is under-assessed, and they are less likely to receive opioid and non-opioid-based medications.⁷⁹ Focus group research with Black elders underscored this point: "We say we're in pain. But they might not even check it, because they assume we can tolerate pain more than other people," said one Black adult.⁸⁰

Black elders also have persistently higher rates of disability relative to white adults.⁸¹ While about 28 percent of all older Americans say they are hindered by one or more age-related difficulties, such as diminished mobility, vision, hearing, motor skills, and cognitive skill, more than 38 percent of Black elders report impairments to daily living activities.⁸² "Black adults may be less likely to have accessible home environments. For example, a decline in the share of white adults who have trouble bathing may reflect better physical function or an increase in the availability of walk-in showers in white households."⁸³

Recommendations set forth in this chapter that are directed at remedying health inequities among African American Californians more generally will also help remedy the specific disparities faced by African American elders. In addition to those important recommendations, the Task Force urges that, as part of the Legislature's authorization and

ongoing funding for the California Health Equity and Racial Justice Fund within the California Department of Public Health's Office of Health Equity, there should be a specific focus on initiatives to remedy the disparities faced by African American elders, with special consideration for African American elders who are descendants of persons enslaved in the United States. Specifically, the Task Force recommends that the Legislature (1) focus on

increased accessibility to medications and treatments for heart attack, stroke, and diabetes among African American elders, which may reduce the severity of disablement; and (2) focus on providing greater access to assistive devices (such as walkers and wheelchairs) and changes to living environments (such as grab bars and ramps), which may contribute to better physical function among African American elders.⁸⁴

Additionally, in order to better track, understand, and respond to these disparities in the future, the Task Forces recommends that the Legislature instruct and fund the California Department on Aging to partner and contract with African American led and serving community-based organizations and on-the-ground grassroots organizations to develop a web-based semiannual State of the State of Older African American Adults in California report.

Remedy the Disparity in Use of and Satisfaction with End of Life Care

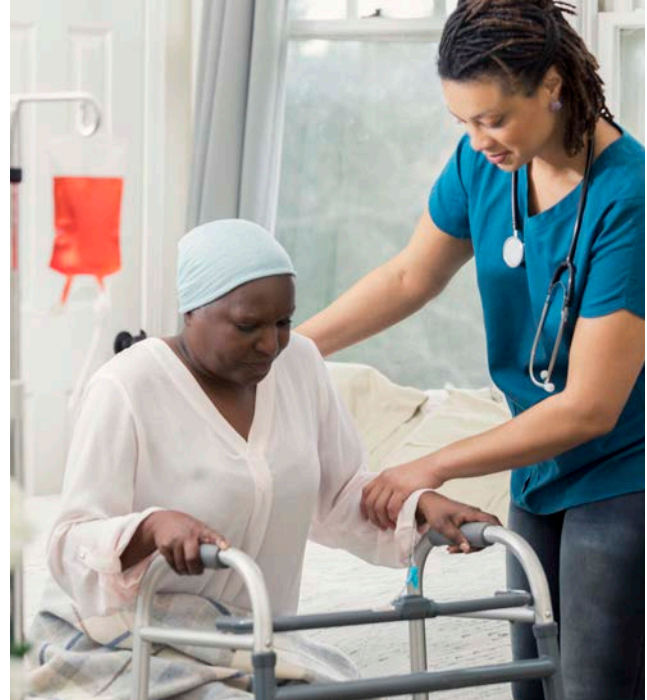
African American elders face disparities in the use of and satisfaction with End of Life (EOL) services and care. The objective of EOL care is to provide “goal-concordant” care based on what the patient and family value and want.⁸⁵ Despite care that is not goal-concordant being considered as a “medical error,” studies have shown that African American elders have a higher rate of “non-goal-concordant care” than white Americans.⁸⁶ Some of this may arise out of the fact that EOL care can frequently dismiss and disregard certain types of belief systems, such as the hope for a miracle and the belief in God as the final arbiter.⁸⁷ African American elders deserve care that is equitable and preserves the life that their loved one has lived and acknowledges their faith and beliefs.

Inferior care results in African American elders being less likely to utilize EOL services compared to white Americans. Specifically, African American elders have advance care planning completion rates that are substantially lower than white Americans, and they are more likely to pursue informal EOL planning.⁸⁸ Yet, even when Black elders have their preferences recorded, they are less likely than white Americans to have their preferences upheld by clinicians in hospitals.⁸⁹ Moreover, African American elders are less likely to use hospice services at the end of life, and are more likely to experience difficult disruptions in care due to being hospitalized.⁹⁰

In order to remedy these disparities in EOL and hospice care, the Task Force recommends the Legislature fund an increase in culturally responsive end-of-life programs and community-based participatory research to improve such programs. Historically, EOL care has been rooted in white middle-class cultural and religious

values, with a different frame of reference, value system, and life experience than most African American elders. Considering patients’ and families’ cultures is essential in all aspects of palliative care.⁹¹

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Home healthcare nurse helps a female cancer patient get out of bed by using a walker.

Funding to increasing culturally responsive end-of-life programs should include the involvement of healthcare workers from diverse backgrounds to help create advance directives that address the concerns and needs of African American elders.⁹² With improved culturally relevant communication, patients and families are more likely to receive useful information about their diagnosis more easily. Future work should be directed at training providers in having discussions that incorporate patient beliefs. Trainings should be based on African American community recommendations in an attempt to move towards health equity.⁹³

Remedy the Harms from Disparity in Insurance and Senior Benefits

Black elders are less likely than their white peers to have private insurance and more likely to rely on Medicaid (the government insurance program for those with low income) or Medicare (the government insurance program for those 65-and-older or permanently disabled) as their only health insurance.⁹⁴ Specifically, where 46 percent of all older adults were covered by both private insurance and Medicare, only 32 percent of Black elders had both private insurance coverage and Medicare.⁹⁵ Compared to white Americans, nearly twice as many Black elders relied on both Medicare and Medicaid.⁹⁶

The higher reliance on government health insurance programs among Black elders reflects the unaffordability of healthcare due to pervasive income disparities. For example, the median income for Black Medicare enrollees is \$17,350, compared to \$30,050 for white enrollees; and nearly one-fourth of Black elders have no supplemental coverage to help defray the cost of inpatient care covered by Medicare Part A or its \$1,400 deductible; in comparison, only 16 percent of white Medicare recipients have no supplemental coverage.⁹⁷

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Black elders who are beneficiaries of Medicare are also more likely than their white peers to receive care in emergency rooms and nursing homes and report fewer doctor's office visits.⁹⁸ Moreover, "research shows that older Black . . . Medicare enrollees commonly experience racism when seeking care, report communication challenges with their providers, and have difficulty affording and accessing regular care."⁹⁹ For example, 37 percent of Black Medicare recipients describe their health as fair or poor, compared to 24 percent of white recipients, and 39 percent of Black Medicare recipients have one or more disabilities.¹⁰⁰

"While they compose 9 percent of the 65-and-older population, Black elders make up more than 14 percent of residents in nursing homes, even though the cost is significantly more than that for an assisted living facility."¹⁰¹ "However, most if not all expenses in assisted living facilities are paid by the tenant, while most Black nursing home residents rely on Medicaid to cover the costs . . ."¹⁰² Whereas 70 percent of older white adults have annual incomes of \$30,000 or more—with 40 percent receiving \$60,000 or more—65 percent of Black elders receive less than \$30,000 a year.¹⁰³ Additionally, Black elders are more likely to reside in nursing homes with low ratings and a history of citations for violations of health and safety standards—forty percent of Black nursing home residents live in lower-tier facilities, compared to 9 percent of white residents.¹⁰⁴ "According to the Nursing Home Abuse Center, African American residents are three times more likely to be physically, emotionally, sexually, and/or financially abused than are white residents."¹⁰⁵

Finally, social security benefits are based on the person's earnings and are thus also lower on average for Black elders, with the typical older Black family receiving annual benefits approximately 24 percent lower than white families.¹⁰⁶

In order to remedy the disparities in insurance and quality of healthcare provision, the Task Force recommends the Legislature create a fund to support and ensure that African American seniors in California have an annual income that is tied to the Elder Index in their respective county.¹⁰⁷ This would help ameliorate the disparities in social security benefits and the hardships that come from lack of private insurance and the ability to supplement care through Medicare and Medicaid. The recommendation earlier in this chapter regarding adoption of a comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all African American residents of California or for resident descendants would also help remedy the disparities described here.

In order to remedy the disparate treatment African American elders receive in nursing home facilities, the Task Force recommends the Legislature require the Long-Term Care Ombudsman Program to incorporate and require racial bias training for Ombudsman representatives and care providers; create a racial justice unit to investigate bias claims; and fund research into specific ways to increase the wellness of African American elders in long term care facilities in California.

Close the Digital Health Access Divide for African American Elders

As the COVID-19 pandemic brought into clear focus, a fast and secure internet connection is no longer a luxury—it has become central to accessing health services, safety information, and necessary provisions. Yet there is a marked disparity in African American elders' access to high speed internet. Only 30 percent of Black elders have broadband access at their homes, compared to 51 percent of white older adults.¹⁰⁸ And Black elders are one-fifth as likely to own a computer compared to older white adults, while Black elders who receive Medicaid assistance are half as likely to own a computer.¹⁰⁹

Moreover, even for those African American elders with computers and high speed internet, many still struggle to navigate this technology. "Telehealth visits, online grocery shopping, COVID vaccine signups, and more are all made more difficult because of a lack of proper technology literacy."¹¹⁰

To facilitate needed access to telehealth, caregiving supports, and emergency services, the Task Force recommends that the Legislature ensure that all African American elders, especially those who are descendants of a person enslaved in the United States, have personal access to low-or-no cost, high speed, broadband internet services. Additionally, the Task Force recommends the Legislature ensure funding for programs that address the ancillary technology access issues, including internet education training, grants to purchase computers for low-income seniors, and virtual technical services.

Remedy Disparities in Oral Health Care

Oral health is closely linked to chronic diseases such as stroke, heart disease, and diabetes.¹¹¹ According to the U.S. Centers for Disease Control and Prevention (CDC), most dental diseases are preventable, yet children still suffer from dental disease due to inadequate home care and lack of access to dental services.¹¹² Poor oral health has been linked “to decreased school performance, poor social relationships and less success later in life.”¹¹³

As in other areas of health, African Americans disproportionately suffer these harms. Recent data confirm that “there are persistent and significant disparities in [tooth decay] experience and untreated [tooth decay] between non-Hispanic Black and non-Hispanic [w]hite populations.”¹¹⁴ The data also show that there are significant racial disparities in the prevalence of periodontal disease, severe periodontitis, and tooth loss, as well as oral and oropharyngeal cancer survival rates.¹¹⁵ Studies have also found that structural racism contributes to oral health disparities.¹¹⁶ For example, studies have found that: Black populations have poorer access to preventive services; dentists’ treatment decisions are affected by implicit bias; treatment recommendations favored extractions versus root canal treatments for Black patients; and there is a substantial underrepresentation of Black dentists in the dental profession and workforce.¹¹⁷ The findings of these studies dovetail with what experts have identified as barriers to oral health care for African Americans: (1) a shortage of Black dentists; (2) a shortage of Black dental students; (3) a lack of dentists in communities of color; (4) implicit bias among dental care providers; and (5) affordability and access to insurance coverage.¹¹⁸ Another study confirms that insurance coverage, treatment costs, and access to care influence oral health disparities among African American men.¹¹⁹

Four solutions to improve oral health care emerged from a recent survey of African American seniors. These solutions include: (1) better oral health education, starting at a younger age; (2) free or at least affordable (reduced cost) dental care and vouchers for dental work; (3) provision of onsite community dental services; and (4) navigators to help educate community members about insurance payment options and available low-cost providers.¹²⁰ Survey respondents also suggested incorporating more dental education in schools through pamphlets for kids and parents and having dental professionals visit senior centers to provide services and education.¹²¹

Additionally, the CDC has identified that school sealant programs are effective in preventing cavities in millions of children.¹²² Specifically, school sealant programs involve providing pit and fissure sealants to children aged 6 to 11 or in grades 1 through 5; the programs also include licensed dental professionals screening children for oral disease and checking whether they already have sealants.¹²³ This is done via signed permission slips from parents and guardians for dental sealants to be applied, typically at no cost.¹²⁴ The CDC noted that states can assist by: (1) “Targeting school-based sealant programs to the areas of greatest need;” (2) “Tracking the number of schools and children participating in sealant programs;” (3) “Implementing policies that deliver school-based sealant programs in the most cost-effective manner;” and (4) “Helping schools connect to Medicaid and the Children’s Health Insurance Program (CHIP), local health department clinics, community health centers, and dental providers in the community to encourage more use of sealants and reimbursement of services.”¹²⁵

The data also show that there are significant racial disparities in the prevalence of periodontal disease, severe periodontitis, and tooth loss, as well as oral and oropharyngeal cancer survival rates.

The Task Force recommends that the Legislature establish and fund a program like UC PRIME¹²⁶ for University of California and California State University dental programs to be focused on working with, and providing oral health care in, African American communities.

The Task Force also recommends that the Legislature add the completion of an anti-bias training and an assessment based on such training to the graduation requirements of all dental schools in California receiving

state funding and to the requirements for licensure by the Dental Board of California for licensed dentists and registered dental assistants.

The Task Force recommends, in conjunction with its recommendation to establish and fund community wellness centers in African American communities to deliver services in a manner that is culturally congruent with African American culture, that the health care advocates staffing these centers also help their clients navigate insurance payment options and find low-cost providers.

The Task Force also recommends that the Legislature implement school sealant programs in California elementary schools, which will also include oral health education.

Finally, the Task Force recommends that the Legislature fund oral health care to underserved populations in the African American community, including seniors, by authorizing state funding for mobile dental clinics, preferably within trusted community-based organizations, which may be achieved through a state-funded grant-making program.¹²⁷

Fix Racially Biased Algorithms and Medical Artificial Intelligence in Health Care

Researchers have established that there is evidence of significant racial bias in a widely-used commercial algorithm developed by health services company Optum to guide decisions in the United States health care system.¹²⁸ Specifically, researchers noted that bias occurs in this algorithm because it used health costs as a proxy for health needs.¹²⁹ Because less money is spent on Black patients who have the same level of needs as white patients, the algorithm incorrectly assumes that Black patients are healthier than equally sick white patients.¹³⁰ Accordingly, Black patients had to be much sicker than white patients in order to be recommended for the same care.¹³¹ Optum has replicated the study with the same researchers and saw an 84 percent reduction in bias with a new algorithm that uses health prediction in conjunction with cost.¹³²

Despite this change, racial bias has been found in other medical technology. An ACLU paper provides four examples of racial bias in medical artificial intelligence (AI), medical devices, and algorithmic decision-making tools, which include:

1. An AI tool meant to decide how to best distribute the limited resource of extra care to new mothers at risk of postpartum depression was found to show racial bias—directing care away from Black mothers and favoring White mothers[;]
2. A widely used clinical algorithm indicating kidney health is adjusted based on whether a patient is Black, and systematically indicates Black patients are healthier than they may actually be; in fact, an October 2020 study found that without this explicit race-based adjustment, nearly a third of Black patients would be reclassified as having more severe kidney disease. (Only in September 2021, after increased pressure from lawmakers and advocates, was the algorithm updated to remove the use of race. Still, recent reports suggest the old algorithm is still being used by federal courts to make determinations about health-based early prison release despite litigation indicating that it functions in a clearly biased way.)[;]
3. A recent meta-analysis found the vast majority of machine learning (ML) studies in dermatology did not include information on different skin tones as part of algorithm development. As a result, the validity of model results varied based on skin tone, with some models performing worse on darker skin[; and]
4. A 2020 study on pulse oximeters, a medical device used especially in the COVID-19 pandemic to monitor patients' oxygen levels, detailed that the devices are less accurate among patients with darker skin and could even increase risk of adverse health outcomes for those patients. In fact, a 2022 retrospective study confirmed that patients of color, likely due to this known bias, received less supplemental oxygen than White patients, contributing to their morbidity. While this is a hardware issue, it shows an existing bias associated with patient[s'] skin color in medical devices[;] instances like this are alarming considering that this issue was arguably more predictable than issues that may arise from the use of AI as a medical device.¹³³

Bias in commercial algorithms can have harmful effects on African American patients at all points in the health care process, from the triaging of illness to the quality of care received.¹³⁴ These algorithms “also lack data diversity, whether by race, sex, or other factors,” and the lack of data diversity “diminishes the generalizability of these studies and potentially of the tools developed using the data.”¹³⁵ As the ACLU paper notes, there is no single agency regulating AI tools and clinical algorithms that are in use today, but “[i]nstead, a patchwork of regulatory powers has led to gaps and permitted the continued use of potentially harmful technologies without sufficient oversight.”¹³⁶

Experts such as Ashish Jha, previously the director of the Harvard Global Health Institute, believe that bias in algorithms is far easier to eradicate than human bias. Jha noted: “Algorithms that are built well with these issues

taken into account can help doctors overcome subtle unconscious biases they may have . . . Data and algorithms have a lot of potential to do good, but what this study reminds us of is that if you don't do it right, you have a lot of potential to do harm."¹³⁷

Based on the foregoing and the recommendations listed in the ACLU paper,¹³⁸ the Task Force recommends that the Legislature provide state funding to the California Department of Public Health, a University of California or California State University center or department, or another appropriate entity to study the potential for harmful biases in commercial algorithms and AI-enabled medical devices, and "evidence-based research into the use of devices and tools that recommend adjusting patients' treatment or medication based on broad racial categories in the absence of information on genetics or socio-cultural risk factors."¹³⁹ This study should also include recommendations on how best to regulate commercial algorithms and medical artificial intelligence tools in California.

The Task Force also recommends that the Legislature require the California Department of Public Health to issue guidance to hospitals and other medical systems to ensure that commercial algorithms and AI-enabled medical devices "are not used for clinical applications without FDA approval or clearance, are not used on patient populations they were not intended for, and that cleared tools are not used outside of their intended use cases"¹⁴⁰

"Algorithms that are built well with these [bias] issues taken into account can help doctors overcome subtle unconscious biases they may have . . . Data and algorithms have a lot of potential to do good, but . . . if you don't do it right, you have a lot of potential to do harm."

The Task Force further recommends that the Legislature authorize the California Department of Public Health "to make and maintain a public list of software as a medical device (SaMD) products and provide demographic information about the subjects in which the devices were calibrated or trained."¹⁴¹

Finally, the Task Force recommends that the Legislature allocate positions and funding to the California Department of Justice to pursue claims against algorithm and AI-enabled medical device manufacturers if these products have a disparate impact when providers

use it according to manufacturers' instructions or if the products misleadingly promise fairness.

Fund and Expand the UC PRIME-LEAD-ABC Program to be Available at All UC Medical Campuses

African American physicians and patients have experienced historic and ongoing discrimination in all aspects of the health care system.¹⁴² After the end of the Civil War, federal, state, and local governments continued to deny African Americans adequate health care through numerous policies, including through the Hill-Burton Act, which funded the creation of the modern hospital infrastructure by funding segregated hospitals, including many throughout California.¹⁴³ Even after the end of formal segregation policies, the government failed to address their lasting, discriminatory effects—for instance, one news report suggests that Black resident physicians are disproportionately dismissed and reprimanded for transgressions that go unpunished for white resident physicians,¹⁴⁴ and a number of Black physicians in California have brought lawsuits alleging that hospital systems in the State have enacted "pervasive hostility against Black professionals and medical students."¹⁴⁵ This discrimination against Black physicians has, in turn, reinforced discriminatory denial of adequate care for Black patients. While Black Californians make up approximately six percent of the state's population, only three percent of active patient care physicians

in California are Black.¹⁴⁶ And a 2021-2022 study found that nearly one in three African Americans in California have been treated unfairly by a health provider because of their race or ethnicity.¹⁴⁷

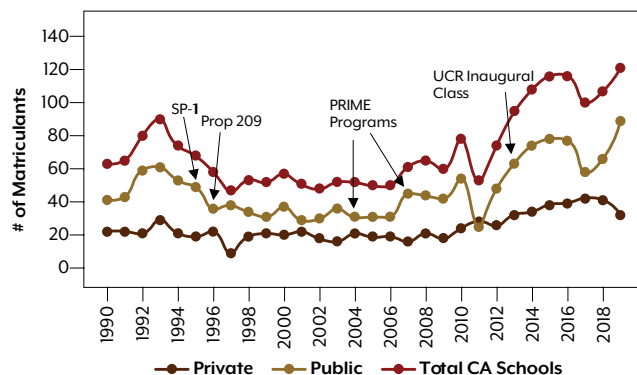
To address inequities in health care and increase the number of African American physicians serving African American communities, with special consideration

for descendants, the Task Force recommends that the Legislature provide funding to allow the University of California permanently expand the UC PRIME-LEAD-ABC program—which includes a specialized curriculum, training experiences, and dedicated faculty mentorship to train and recruit physicians to serve in the programmatically-defined predominantly African, Black, or Caribbean (ABC) communities—to be available on all UC medical campuses.¹⁴⁸ To the extent that the UC PRIME-LEAD-ABC program does not currently give special consideration to those who are descendants of individuals enslaved in the United States, the Task Force recommends the Legislature fund a special program to

allow the University of California create an equivalent pathway program specifically for this group. And the Task Force recommends that the Legislature include funding for the UC PRIME-LEAD-ABC programs to expand their mentorship and support services to include comprehensive mental health support, especially regarding racial stress and trauma, and that such mental health support services continue to be provided to participants after they complete the UC-PRIME-LEAD-ABC program.¹⁴⁹

Surveying existing literature on the effects of the UC PRIME programs, one 2022 report found that the UC PRIME programs added significant numbers of African Americans to the UC system's medical schools.¹⁵⁰ From 1990 to 2019, the annual number of African American medical students in California rose from 63 to 121 students, with “[p]ublic medical schools account[ing] for most of this increase.”¹⁵¹ Additionally, care by African American physicians can address the discriminatory treatment that African American patients might otherwise receive when seeking healthcare.¹⁵²

Proportion of African American matriculants to public and private California medical schools (1990 – 2019)



In addition to increasing the number of African American medical professionals serving African American communities, the Legislature should: (1) fund grants providing scholarships or loan forgiveness to African American medical students, physician assistants, and nurse practitioners who commit to serving African American communities; and (2) fund grants providing scholarships or loan forgiveness to medical students, physician assistants, and nurse practitioners who are descendants and who commit to serving predominantly African American communities. To the extent that the Legislature implements a loan forgiveness program, eligibility for loan forgiveness programs should, at minimum, include African American medical professionals serving African American communities through community-based organizations.

Create and Fund Equivalents to the UC-PRIME-LEAD-ABC Program for Psychologists, Licensed Professional Counselors, and Licensed Professional Therapists

As described in Chapter 12, Mental and Physical Harm and Neglect, the historic and ongoing discriminatory health harms to descendants include inadequate access to mental healthcare—a harm compounded by the stress and trauma of ongoing racial discrimination experienced by African Americans in California, including descendants.¹⁵³ To address unequal access to mental healthcare services, the Task Force recommends that the Legislature create and fund equivalents to the UC PRIME-LEAD-ABC programs for recruiting and training psychologists (Ph.D. and Psy.D. programs) and licensed professional counselors and therapists (master's programs) committed to serving predominantly African American communities, with special consideration for descendants. The Task Force also recommends that funding for these program include comprehensive mental health support, especially regarding racial stress and trauma, and that program participants continue to receive such mental health support services after students complete their program.¹⁵⁴

Due to ongoing disparities and discrimination in mental health care, experts have called for the state to expand funding for educational capacity, stipends, and scholarships to strengthen the size, distribution, and diversity of the mental health and behavioral health workforce.¹⁵⁵ As noted above, the UC PRIME programs present successful models for programs that both recruit and mentor African American medical professionals while also increasing the number of medical professionals dedicated to serving predominantly African American communities.¹⁵⁶ While the State of California has enacted various measures to increase the overall supply of mental health professionals, these prior policies do not appear to involve any targeted effort to increase the number of African American or other professionals serving African American communities specifically.¹⁵⁷

In addition to increasing the number of African American mental health professionals serving predominantly African American communities, the Legislature should: (1) fund grants providing scholarships or loan forgiveness to African American mental health professionals who commit to serving predominantly African American communities; and (2) fund grants providing scholarships or loan forgiveness to mental health professionals who are descendants and who commit to serving predominantly African American communities. To the extent that the Legislature implements a loan forgiveness program, eligibility for loan forgiveness programs should, at minimum, include African American mental

health professionals serving African American communities through community-based organizations.

Permanently Fund the California Medicine Scholars Program and Create and Fund Equivalent Pathway Programs for Students in the CSU and UC Systems

Historic and ongoing discrimination against African Americans in California has produced a myriad of barriers throughout the pathway to becoming a healthcare provider, including financial barriers; lack of access to mentorship; lack of access to academic advising; and a dearth of opportunities to participate in academic and summer enrichment programs relating to science, technology, or medicine.¹⁵⁸

To remedy the discrimination that has excluded African Americans in California from the field of medicine and denied African Americans in California equal and adequate healthcare,¹⁵⁹ the Task Force also recommends that the Legislature permanently fund the pathway initiatives in the California Medicine Scholars program and create an equivalent pathway program for students in the CSU and UC systems. The California Medicine Scholars Program (CMSP) was created to connect community college students to medical schools, clinics, and medical practitioners to promote pathways for underrepresented college students to enter the field of medicine.¹⁶⁰ Students from an eligible community college can apply to the program, which partners them with a medical school in one of four nearby geographic regions.¹⁶¹ The program then provides mentorship by medical practitioners, academic advising, enhanced curriculum, and priority enrollment to that student when the student applies to that particular medical school.¹⁶²

Several studies over the last four decades have found that participation in pathway programs improves the odds of medical school matriculation among students, including African American students from excluded backgrounds.¹⁶³

In addition, the Legislature should expand or create pathway programs like the CMSP to: (1) create similar pathway programs for high school students; and (2) create pathway programs for other medical professions, such as physician assistants and nurse practitioners.¹⁶⁴ Because “literature that describes or evaluates nursing pathway programs” or pathways to other health care professions “is scarce,”¹⁶⁵ if the Legislature expands the creation or funding of pathway programs to include other medical professions, such as nurses and physician assistants, the Task Force further recommends that the Legislature fund an accompanying study of such pilot

programs to ensure that the programs are equally effective in improving recruitment and retention of African Americans in other medical professions.

COURTESY OF PIXELCATCHERS VIA GETTY IMAGES



Nurse talks to doctor in corridor.

Review and Prevent Racially Biased Disciplinary Practices by the Medical Board of California

A report by the California State Library Research Bureau—reviewing California Medical Board data from 2003 to 2013—found that African American physicians in California were more likely to be the subject of complaints, and the Board was more likely to investigate a complaint brought against an African American physician than a white physician.¹⁶⁶ To remedy discrimination in physician discipline, the Task Force recommends legislation to review and prevent racially biased disciplinary practices by the California Medical Board (Board) in its investigatory and disciplinary proceedings by implementing the following:

1. Requiring the Board to permanently staff and train its Disciplinary Demographic Task Force, which finds training opportunities to eliminate implicit bias and reviews the Board’s processes for such bias.¹⁶⁷
2. Requiring the Board to undergo implicit bias training.
3. Requiring an annual, third-party review of the Board’s investigatory and disciplinary records to determine racial disparities in its investigatory or disciplinary practices.
4. In the event that an annual review uncovers racial disparities in the Board’s investigatory or disciplinary practices, requiring the Board to enact any other measures necessary to directly remedy any discriminatory actions taken by the Board (for example, reinstating a license if the suspension process was affected by racial animus).

Address Food Injustice

Black households disproportionately experience food insecurity.¹⁶⁸ As discussed in Chapter 12, Mental and Physical Harm and Neglect, predominantly African American communities also disproportionately experience highly limited access to affordable, nutritious food, and are often inundated with unhealthy options like sugary drinks and processed or fast food.¹⁶⁹ High densities of liquor stores and tobacco shops in these communities also pose a public health concern because of their link with violent crime.¹⁷⁰ The resulting health harms are stark.¹⁷¹ Redlining, bolstered by other government and government-enabled discrimination, is a central cause of this food injustice.¹⁷²

In order to remedy these harms, and to improve access to affordable, nutritious food, the Task Force recommends a slate of measures including: improving supermarket and grocery store access in African American communities; increasing the number of farmers markets and community gardens in these communities; supporting healthy food retailing and limiting liquor and tobacco stores; and funding descendants and trusted community-based organizations to launch and sustain urban agriculture ventures, grocery stores and cooperatives, farmers markets, mobile food vending operations, and related infrastructure needed to bring food justice to African American communities, with special consideration for African Americans who are descendants of persons enslaved in the United States.

Improve Supermarket Access

One of the harms facing African American communities in California is the lack of access to grocery stores and supermarkets.¹⁷³ White neighborhoods on average have four times as many supermarkets as predominantly African American neighborhoods, and grocery stores in African American communities typically are smaller and have less selection.¹⁷⁴ There are a number of approaches the Task Force recommends to begin remediating this harm.

First, to ensure a coordinated and continued response to these harms, the Task Force recommends that the Legislature continue to fund the California Healthy Food Financing Initiative Council, which is tasked with expanding food access by developing financing options, partnering with state, local, nonprofit, and philanthropic programs, and providing updates to the Legislature.¹⁷⁵ The Healthy Food Financing Initiative Council has supported regional food hubs in locations like hospitals, schools, and corner stores, where buyers can purchase local food at reasonable prices and with reduced transaction costs. The Council also assists food hubs to develop

capital funds and conduct outreach to farmers. The Council has also aimed to increase new grocery stores in underserved areas, to increase access to healthy foods, lower food costs by facilitating access to funds and grants, and encourage local governments to speed approvals and permits. An additional aim has been to increase healthy food sold at current stores by assisting stores with access to funds and connecting them with technical assistance with sourcing, storage, store design, and marketing assistance.¹⁷⁶ In addition to recommending the continuation of the Council's funding, the Task Force recommends that the Legislature amend the Council's mission to include an explicit provision for a committee focused on the needs of the African American community.

Second, the Task Force recommends that the Legislature provide economic or other incentives to support the development of supermarkets in African American communities that lack adequate access.¹⁷⁷ These incentives may include tax breaks and grants to support non-profit grocery cooperatives.

Third, to improve the development process for such stores, the Legislature should also facilitate the adoption of zoning laws to support the siting of supermarkets in underserved African American communities.¹⁷⁸ In conjunction with the above, the Task Force also recommends that the Legislature study the continuing impacts of restrictive zoning laws and the California Environmental Quality Act (CEQA) process on the development of new grocery outlets in underserved African American communities for the purpose of identifying and adopting additional measures needed to remove remaining barriers to siting grocery stores in these communities.

Fourth, in order to remedy the harms from abrupt disruptions in access to food, the Task Force recommends that the Legislature consider requiring advance notifications to the affected community, employees, and other stakeholders, prior to the closure of a grocery store in underserved or at-risk African American communities.¹⁷⁹ Such notice should be meaningful and adequate for the circumstances and include informing the California Department of Social Services and local entities of a planned closure, and should also include the identification of the three nearest grocery establishments that provide comparable service. The Legislature should also consider requiring county human services departments to provide grocery establishments that have announced a closure with information about public social services for which employees may be eligible.

Additionally, cities should be required to monitor grocery store closures to assess potential trends.¹⁸⁰

Fifth, to the extent that regulations and contracting provisions are at fault for the lack of grocery stores in African American communities, the Task Force recommends that the Legislature prohibit covenants and lease provisions that prevent the operation of grocery stores in these communities.¹⁸¹

Finally, as discussed in Chapter 7, Racism in Environment and Infrastructure, African American communities often have fewer and worse public transit options.¹⁸² In order to remedy this harm, the Task Force recommends that the Legislature tie a portion of funding for local governments to the planning and implementation of public transportation routes and schedules that maximize access to supermarkets in African American communities.¹⁸³

Support and Expand Farmers Markets and Community Gardens

As discussed in Chapter 12, Mental and Physical Harm and Neglect, African Americans in Californian are more likely to live in areas without access to full-service grocery stores and areas in which residents have few or no convenient means of securing affordable, healthy foods like fresh fruits and vegetables.¹⁸⁴ In addition to increasing access to full-service grocery stores, increas-

whole foods in African American communities, formerly redlined neighborhoods, and other neighborhoods that are home to African American families lacking adequate access.¹⁸⁵

First, with regards to farmers markets, the Task Force recommends that the Legislature use requirements for zoning laws and land use policies to create and encourage localities to create new space for farmers markets in African American communities.¹⁸⁶ Additionally, the Task Force recommends the Legislature provide government subsidies or create public-private partnerships to develop new farmers markets in these areas, and provide financial support for the marketing of such markets to the community.¹⁸⁷ Moreover, given the transit issues discussed in Chapter 7, Racism in Environment and Infrastructure, and to ensure access to such markets, the Task Force recommends that the Legislature provide financial support for transportation to farmers markets and increase incentives for local transit agencies to ensure their routes include access to farmers markets from African American communities.¹⁸⁸ Finally, given the economic hardships discussed in Chapter 13, The Wealth Gap, the Task Force recommends the Legislature continue to encourage and, where possible, require farmers markets to accept electronic benefits from food assistance programs such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and Supplemental Nutrition Assistance Program (SNAP).¹⁸⁹

Second, given the potential of community gardens and urban farming to help remedy the food access issues described above and to help furnish fresh produce to African American communities, the Task Force recommends that the Legislature promote community gardens and urban gardens in these communities through zoning policy and grants or other financial support, in addition to encouraging local municipalities to change zoning policies to promote such spaces.¹⁹⁰

Third, the Task Force recommends that the Legislature increase farm-to-school and farm-to-institution programs in African American communities, and develop government procurement processes that specifically support local African American farmers in regards to these programs.¹⁹¹



Man gathering vegetables in community garden.

ing access to farmers markets and community gardens can help remedy the harms faced by African American communities. Thus, the Task Force recommends the following actions in order to increase access to farmers markets and community gardens offering organic and

Enhance Healthy Food Retailing and Curtail the Proliferation of Unhealthy Food Retailing

As discussed in Chapter 12, Mental and Physical Harm and Neglect, African American communities have an overconcentration of liquor stores and tobacco stores, which are correlated with health problems for African Americans.¹⁹² Moreover, African American communities are specifically targeted by marketing agencies for sugar-sweetened beverages. For example, Black children and teens see more than twice as many ads for certain sugar drinks than their white peers, and lower-income Black neighborhoods have disproportionately more sugary drink ads on billboards, bus benches, sidewalk signs, murals, and store window posters.¹⁹³ And sugar has had disproportionate negative consequences for African Americans, as it is linked to diabetes and hypertension.¹⁹⁴ To remedy these harms, the Task Force recommends proposals aimed at limiting certain stores in African American communities; encouraging more fresh produce and other health foods at existing stores; and encouraging the increase of other informal methods of healthy food delivery in these communities.

First, the Task Force recommends that the Legislature enact standards that will lead to local zoning restrictions limiting the number of liquor stores and tobacco shops per neighborhood in African American communities.¹⁹⁵ In conjunction with this, the Task Force recommends that the Legislature support or require the enactment of zoning laws that create buffer zones restricting liquor stores and tobacco shops around schools and recreation areas in these communities.¹⁹⁶

Second, the Task Force recommends that the Legislature offer financial incentives (such as reduced taxes and fees) to encourage small store owners in African American communities to offer fresh produce and healthier foods.¹⁹⁷ In conjunction with this, the Task Force recommends that the Legislature incentivize restaurants in African American communities to reformulate menu items to provide healthier options.¹⁹⁸

Third, in order to increase the availability of fresh produce and counter the prevalence of sugary beverages, the Task Force recommends that the Legislature enact legislation to facilitate the provision of permits and incentives to healthy mobile vending carts in African American communities.¹⁹⁹ To help to effectuate a healthy food environment, the Task Force also proposes that the Legislature require the California Healthy Food Financing Initiative Council to assess further opportunities for innovations and partnerships to increase access to affordable, nutritious food and to reduce the saturation of liquor stores and tobacco shops in African American communities. As part of this work, the Task

Force recommends that the Legislature require the Council to support the development and ongoing work of local Food Policy Councils (which bring together stakeholders to assess how food systems operate at the local level and formulate recommendations for improvements) in formerly redlined communities and predominantly African American communities with limited access to affordable healthy food.²⁰⁰

Additionally, the Task Force recommends that the Legislature amend the Food and Agricultural Code to establish legislative findings and declarations regarding the importance of reasonable access to nutritious food for African American communities as a measure to support other efforts going forward. Finally, the Task Force recommends that the Legislature fund community education in African American communities regarding nutrition, health, and resources available to access affordable, nutritious food.

Bringing Nutrition and Economic Opportunity to Communities

As discussed in Chapter 12, Mental and Physical Harm and Neglect, African American communities suffer specific harms in relation to food injustice. Moreover, as discussed in Chapter 10, Stolen Labor and Hindered Opportunity, African Americans have suffered economic harms and been denied fair wages and labor opportunities. In order to address both these areas of harm, the Task Force recommends that the Legislature create and fund a program of grants, low-interest loans, and technical assistance (as needed) for trusted community-based organizations in historically African American communities, formerly redlined neighborhoods, or similar neighborhoods which are home to African Americans who lack adequate and equitable access to affordable, nutritious food options. These grants and low-interest loans would be used to support the creation and ongoing growth and stability of urban agriculture ventures, grocery stores and cooperatives, farmers markets, mobile food vendors, and related infrastructure needed to bring about food justice and stimulate pipelines for healthy, whole foods. While focused on increasing access to nutrition and improved health outcomes, this program of grants and low-interest loans would bring added economic development and employment opportunities and provide some measure of redress for the long history of discrimination against African American farmers and small business owners, especially those who are descendants of an individual enslaved in the United States, in communities that continue to suffer the consequences of redlining and other forms of discrimination.²⁰¹

Endnotes

¹ Chapter 12, Mental and Physical Harm and Neglect.

² *Ibid.*

³ *Ibid.*

⁴ *Ibid.*; [Advancing Black Health Equity](#), California Health Care Foundation (as of May 15, 2023); see also Cummings, [Listening to Black Californians: How the Health Care System Undermines Their Pursuit of Good Health](#) (Oct. 4, 2022) California Health Care Foundation (as of May 15, 2023).

⁵ See, e.g., Note, [Remediating the Health Implications of Structural Racism through Reparations](#) (2022) 90 Geo. Wash. L. Rev. 1018 (as of May 15, 2023); Richardson, et al., [Reparations for Black American Descendants of Persons Enslaved in the U.S. and Their Potential Impact on SARS-CoV-2 Transmission](#) (May 2021) Social Science and Medicine (as of May 15, 2023); Bassett and Galea, [Reparations as a Public Health Priority—A Strategy for Ending Black-White Health Disparities](#) (Nov. 26, 2020) 383 N. Engl. J. Med. 2101, 2102 (as of May 15, 2023); Bassett, [Reparations Will Save Black Lives](#) (Sept. 30, 2022) Harvard Public Health (as of May 15, 2023); Morgan and Reid, [On Answering the Call to Action for COVID-19: Continuing a Bold Legacy of Health Advocacy](#) (Jun. 5, 2020) 112(3) J. Nat'l Med. Assoc. 324 (as of May 15, 2023).

⁶ Glenn, [Social Determinants of Health Are Important Contributors to Mortality Disparities in U.S., Study Finds](#) (Aug. 11, 2022) Johns Hopkins Medicine (as of Feb. 15, 2023).

⁷ Artiga and Hinton, [Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity](#) (May 10, 2018) Kaiser Family Foundation (as of Jan. 20, 2023).

⁸ Bedayn, [Community Groups Renew Push for Health Equity and Racial Justice Fund](#), Cal Matters (Feb. 9, 2022) (as of Jan. 20, 2023).

⁹ The Legislature included the Health Equity and Racial Justice Fund in their

version of the 2021-2022 state budget as a part of a larger public health package intended to reduce racial disparities. (Bedayn, *Community Groups, supra.*) However, Governor Newsom's final 2021-2022 budget left out this Fund. (*Ibid.*) The California Senate and Assembly proposed \$75 million in ongoing annual funding for the Fund, but again Governor Newsom ultimately declined to include it in the 2022-2023 budget. (Evans, [Community Groups Criticize Newsom for Omitting Health Equity Funds](#), Los Angeles Times (Jul. 7, 2022) (as of Apr. 11, 2023).)

¹⁰ AB 1038 was introduced in the 2021-2022 Regular Session of the Legislature, but ultimately was not chaptered into law.

¹¹ [We Are All Public Health](#) (March 25, 2022) California Health Equity and Racial Justice Fund (as of Jan. 20, 2023); [Health Equity & Racial Justice Advocates Outraged at Lack of Funding for Communities to Address Disparities](#) (Jun. 28, 2022) Public Health Institute (as of Jan. 20, 2023).

¹² Bedayn, *Community Groups, supra.*

¹³ [Advancing Black Health Equity](#), California Health Care Foundation.

¹⁴ See Finocchio et al., [California Health Care Almanac: Medi-Cal Facts and Figures: Essential Source of Coverage for Millions](#) (Aug. 18, 2021) California Health Care Foundation at p. 5 (as of Jan. 20, 2023).

¹⁵ *Id.* at p. 54.

¹⁶ See Ford and Michener, [Medicaid Reimbursement Rates are a Racial Justice Issue](#) (Jun. 16, 2022) The Commonwealth Fund (as of Jan. 20, 2023).

¹⁷ See generally, Chapter 12, Mental and Physical Harm and Neglect.

¹⁸ For a list of some of the bills passed by the California State Legislature in the 2021-2022 Session impacting access to health care for low-income Californians, see [Health Care Legislation Affecting Low-Income Consumers as of September 13, 2022](#), Western Center on Law and Poverty (as of May 15, 2023).

¹⁹ *Ibid.*

²⁰ [California State Budget](#) (2022-23) pp. 5-6 (as of May 22, 2023).

²¹ *Ibid.*

²² Sen. Conc. Res. No. 17 (2021-2022 Reg. Sess.) as chaptered Apr. 30, 2021. Relatedly, Senate Bill 17 was introduced in 2020, which would have declared racism a public health crisis and would have established the state's first Racial Equity Commission. The bill did not pass, but Governor Newsom established a Racial Equity Commission in September 2022 by executive order. (See Press Release, [Governor Newsom Strengthens State's Commitment to a California For All](#) (Sept. 13, 2022) Office of Governor Gavin Newsom (as of May 15, 2023).)

²³ See Chapter 12, Mental and Physical Harm and Neglect; Thomas et al., [Health Disparities by Race and Ethnicity in California: Pattern of Inequity](#) (Oct. 2021) Cal. Health Care Foundation, p. 2 (as of Jan. 20, 2023); Smedley et al., [Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care](#) (2003) Institute of Medicine (as of Jan. 20, 2023).

²⁴ *Ibid.*

²⁵ Forde et al., [The Weathering Hypothesis as an Explanation for Racial Disparities in Health: A Systematic Review](#) (2013) 7 Sociology Compass 630, 630-643.

²⁶ Matthew, [Just Medicine: A Cure for Racial Inequality in American Health Care](#) (2018) pp. 155-158, citing evidence.

²⁷ *Id.* at p. 176.

²⁸ Bassett, [Reparations Will Save Black Lives](#), *supra.*

²⁹ *Ibid.*

³⁰ *Ibid.*

³¹ Rowen et al., [How to Improve Race, Ethnicity, and Language Data and Disparities Interventions](#) (Sept. 14, 2022) [Health Affairs](#) (as of Jan. 20, 2023); Vega Perez et al., [Improving Patient Race and Ethnicity Data Capture to Address Health Disparities](#) (Jan. 2022) [Cureus Journal of Medical Science](#) (as of Jan. 20, 2023);

Inventory of Resources for Standardized Demographic and Language Data Collection (March 2022) Centers for Medicare and Medicaid Services (as of Jan. 20, 2023); Haley et al., Collection of Race and Ethnicity Data for Use by Health Plans to Advance Health Equity (July 20, 2022) Urban Institute (as of Jan. 20, 2023); James et al., Modernizing Race and Ethnicity Data in our Federal Health Programs (Oct. 26, 2021) The Commonwealth Fund (as of Jan. 20, 2023); Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement, Agency for Healthcare Research and Quality (as of Jan. 20, 2023).

³² California Needs Standards for Demographic and Social Needs Data to Reduce Disparities and Advance Health Equity (as of Jan. 20, 2023) California Pan-Ethnic Health Network.

³³ Sen. Bill No. 1033 (2021-2022 Reg. Sess.).

³⁴ Cummings, Listening to Black Californians: How the Health Care System Undermines Their Pursuit of Good Health (Oct. 4, 2022) California Health Care Foundation (as of Jan. 20, 2023).

³⁵ *Ibid.*

³⁶ *Ibid.*

³⁷ *Ibid.*

³⁸ Cultural congruence is “mutual humility and respect between provider and client,” which “gives a framework for the provider and client to be able to negotiate a treatment plan . . .” (Notgarnie, Cultural Congruence (Jul. 31, 2007) RDH (as of Apr. 11, 2023).) “Culturally congruent practice . . . is in agreement with the preferred cultural values, beliefs, worldview, and practices of the healthcare consumer and other stakeholders.” (Marion, et al., Implementing the New ANA Standard 8: Culturally Congruent Practice (Nov. 18, 2016) 22 Online Journal of Issues in Nursing 1 (as of Apr. 11, 2023).)

³⁹ Boyle, Clinical Trials Seek to Fix Their Lack of Racial Mix (Aug. 20, 2021) Association of American Medical Colleges (as of Feb. 9, 2023).

⁴⁰ Huzar, Only 43% of Clinical Trials Report Race and Ethnicity — What can be

done? (Apr. 21, 2022) Medical News Today (as of Feb. 9, 2023).

⁴¹ Boyle, *Clinical Trials*, *supra*; see also Langreth & Campbell, Alzheimer’s Trials Exclude Black Patients at ‘Astonishing’ Rate (Apr. 19, 2022) Bloomberg (as of Feb. 9, 2023) [noting that Stephanie Monroe, executive director of African Americans Against Alzheimer’s stated: “Drugs will work differently in different populations.”].

⁴² Meadows-Fernandez, Black Participants Are Sorely Absent from Medical Research (Dec. 7, 2018) Leaps.org (as of Feb. 9, 2023).

⁴³ *Ibid.*

⁴⁴ Boyle, *Clinical Trials*, *supra*.

⁴⁵ *Ibid.*

⁴⁶ *Ibid.*

⁴⁷ *Ibid.*; see also Awidi & Al Hadidi, Participation of Black Americans in Cancer Clinical Trials: Current Challenges and Proposed Solutions (May 11, 2021) JCO Oncology Practice (as of Feb. 9, 2023) [noting that “[c]overing indirect expenses like time off from work, childcare, and transportation would theoretically improve access and participation in clinical trials especially for lower-income patients”].

⁴⁸ Boyle, *Clinical Trial*, *supra*.

⁴⁹ Huzar, Only 43% of Clinical Trials Report Race and Ethnicity, *supra*.

⁵⁰ *Ibid.*

⁵¹ Boyle, *Clinical Trials*, *supra*.

⁵² *Ibid.*

⁵³ Awidi & Al Hadidi, *Participation of Black Americans in Cancer Clinical Trials*, *supra*.

⁵⁴ Chapter 12, Mental and Physical Harm and Neglect.

⁵⁵ *Ibid.*; Owens & Fett, Black Maternal and Infant Health: Historical Legacies of Slavery (2019) 109 Am. J. of Pub. Health 1342; see also Butler, California Black Health Network Perspectives: The State of Black Maternal Health in California (Nov. 2021) California Black Health Network, pp. 4-5 (as of Jan. 20, 2023).

⁵⁶ Maternal, Child and Adolescent Health Division, California Pregnancy Mortality Surveillance System: California Pregnancy-Related Deaths, 2008-2016 (2021) Cal. Dep’t of Pub. Health, p. 7 (as of Jan. 20, 2023).

⁵⁷ Chapter 12, Mental and Physical Harm and Neglect.

⁵⁸ *Ibid.*; Sakala et al., Listening to Mothers in California: A Population-Based Survey of Women’s Childbearing Experiences (Sept. 2018) National Partnership for Women & Families, pp. 64, 66 (as of Jan. 20, 2023).

⁵⁹ Rabin, Deaths Among Pregnant Women and New Mothers Rose Sharply During the Pandemic, New York Times (Jan. 27, 2023) (as of Apr. 6, 2023).

⁶⁰ Miller, et al., Childbirth Is Deadlier for Black Families Even When They’re Rich, Expansive Study Finds, New York Times (Feb. 12, 2023) (as of Apr. 6, 2023).

⁶¹ *Ibid.*

⁶² Chapter 12, Mental and Physical Harm and Neglect.

⁶³ Doula Care, California Preterm Birth Initiative, University of California, San Francisco (as of Jan. 20, 2023). The website for the California Preterm Birth Initiative presents an extensive list of medical journal articles detailing research on the impact of doula care. *Ibid.*

⁶⁴ Safon et al., Doula Care Saves Lives, Improves Equity, And Empowers Mothers. State Medicaid Programs Should Pay For It (May 26, 2032) Health Affairs (as of Apr. 30, 2023).

⁶⁵ Chen, Routes to Success for Medicaid Coverage of Doula Care (Dec. 11, 2018) California Preterm Birth Initiative, University of California, San Francisco & National Health Law Program, pp. 10, 11, 12, 18, 19 (as of Jan. 20, 2023).

⁶⁶ This recommendation incorporates some of the proposals in Assembly Bill No. 2258 (AB 2258) (2019-2020 Reg. Sess.). Although AB 2258 would have established a Medi-Cal pilot program to cover doula services in the 14 counties experiencing the highest burden of birth disparities in the state, the bill

also would have required DHCS to provide a number of doula supports.

⁶⁷ The California Omnibus Act, passed by Governor Newsom in 2021, establishes a doula stakeholder workgroup, which is currently working on creating payment models. (See Crumley, [How California's Medi-Cal Program Aims to Advance Health Equity for Pregnant People](#) (July 27, 2022) Center for Health Care Strategies (as of Jan. 20, 2023).) Based on what the workgroup recommends to DHCS, this proposal may not be necessary, or this proposal could be amended.

⁶⁸ Assem. Bill No. 2258 (2019–2020 Reg. Sess.).

⁶⁹ See California Dep't of Public Health, [Black Infant Health](#) (as of May 19, 2023).

⁷⁰ [Data Snapshots: Older Adults in California](#), Justice in Aging (as of Mar. 17, 2023); Administration for Community Living, [2020 Profile of African Americans Age 65 and Older](#) (2020) U.S. Dep't of Health and Human Services, p. 3 (as of Mar. 16, 2023).

⁷¹ Sabin, [How We Fail Black Patients in Pain](#) (Jan. 6, 2020), Assn. of Am. Medical Colleges (as of Mar. 16, 2023).

⁷² Aaron, et al., [Disparities and Racism Experienced Among Older African Americans Nearing End of Life](#) (Dec. 14, 2021) 10(4) Current Geriatric Reports 157 (as of Mar. 16, 2023).

⁷³ [Medicare and Minority Americans](#), Kaiser Family Foundation, pp. 2–3 (as of Mar. 16, 2023).

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and Policy Implications, Issue 41, p. 4 (as of Mar. 16, 2023).

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⁷⁸ *Ibid.*

⁷⁹ *Id.* at 158; Robinson-Lane, [Culturally Responsive Pain Management for Black Older Adults](#) (Mar. 7, 2017) Journal of Gerontology Nurs. pp. 1–8 (as of Mar. 17, 2023).

⁸⁰ Horstman et al., [What an Ideal Health Care System Might Look Like: Perspectives from Older Black and Latinx Adults](#) (Jul. 2022) The Commonwealth Fund (as of Mar. 16, 2023).

⁸¹ Scommegna and Mather, [Key Factors](#), *supra*, at p. 5.

⁸² [Black and Aging in America](#) (2021) National Caucus and Center on Black Aging, p. 17 (as of Mar. 16, 2023).

⁸³ Scommegna and Mather, [Key Factors](#), *supra*, at p. 5, emphasis added.

⁸⁴ *Ibid.*

⁸⁵ Aaron et al., [Disparities and Racism Experienced Among Older African Americans](#), *supra*, at p. 159.

⁸⁶ *Ibid.*

⁸⁷ *Ibid.*

⁸⁸ Sanders et al., [From Barriers to Assets: Rethinking Factors Impacting Advance Care Planning for African Americans](#) (2019) 17 Palliat. Support Care. 306–313 (as of Mar. 17, 2023).

⁸⁹ Mack et al., [Racial Disparities in the Outcomes of Communication on Medical Care Received Near Death](#) (Sept. 27, 2010) 170(17) Archive Intern. Med. 1533–1540 (as of Mar. 16, 2023).

⁹⁰ Aaron et al., [Disparities and Racism Experienced Among Older African Americans](#), *supra*, at p. 159.

⁹¹ *Id.* at p. 160.

⁹² *Id.* at p. 161.

⁹³ *Ibid.*

⁹⁴ Scommegna and Mather, [Key Factors](#), *supra*, at p. 10.

⁹⁵ Black and Aging in America, *supra*, at pp. 7–8.

⁹⁶ *Ibid.*

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¹⁰² *Ibid.*

¹⁰³ *Id.* at p. 18.

¹⁰⁴ *Id.* at p. 19.

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¹⁰⁶ Hope, [It's Time To Champion Better Healthcare For African-American Seniors](#) (Nov., 24, 2022) Grand Rapids African American Health Institute (as of May 18, 2023).

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¹¹³ *Ibid.*

¹¹⁴ National Institute of Dental and Craniofacial Research, [Oral Health in America: Advances and Challenges](#) (2021) U.S. Department of Health and Human Services, National Institutes of Health, at p. 1–11 (as of Jan. 27, 2023).

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¹¹⁶ *Id.* at p. 1–15.

¹¹⁷ *Ibid.*

¹¹⁸ Horace, *5 Barriers, supra* [citing studies].

¹¹⁹ Akintobi, et al., *Assessing the Oral Health Needs of African American Men in Low-Income, Urban Communities* (2018) 12(2) Am. J. Men's Health 326, 335 (as of Jan. 27, 2023).

¹²⁰ Kohli, et al., *Barriers and Facilitators of Dental Care in African-American Seniors: A Qualitative Study of Consumers' Perspective* (Mar. 18, 2020) 11(1) J. Adv. Oral. Res. 23-33 (as of Jan. 27, 2023).

¹²¹ *Ibid.*

¹²² *School Sealant Programs*, Oral Health, Centers for Disease Control and Prevention (as of Jan. 27, 2023).

¹²³ *Ibid.*

¹²⁴ *Ibid.*

¹²⁵ *Ibid.*

¹²⁶ As explained elsewhere in this chapter, University of California's Programs in Medical Education, or UC PRIME, is a formal, innovative training program at University of California medical schools that is focused on training medical professionals to meet the needs of underserved populations in rural and urban California. (*Programs in Medical Education (PRIME)*, UC Health, University of California Office of the President.)

¹²⁷ This could include, for example, mobile dental clinics like the Community Mobile Dental Clinics at Herman Ostrow School of Dentistry at the University of Southern California. (*Mobile Dental Clinics*, Herman Ostrow School of Dentistry at University of Southern California (as of Jan. 27, 2023).)

¹²⁸ Obermeyer et al., *Dissecting Racial Bias in an Algorithm Used to Manage the Health of Populations* (Oct. 25, 2019) 336 Science 447 (as of Feb. 6, 2023); Gawronski, *Racial Bias Found in Widely Used Health Care Algorithm*, NBC News (Nov. 6, 2019) (as of Feb. 8, 2023).

¹²⁹ Obermeyer, *Dissecting Racial Bias, supra*.

¹³⁰ *Ibid.*

¹³¹ Grant, *Algorithms Are Making Decisions About Health Care, Which May Only*

Worsen Medical Racism (Oct. 3, 2022) ACLU (as of Feb. 6, 2023).

¹³² Gawronski, *Racial Bias Found, supra*.

¹³³ Grant, *ACLU White Paper: AI in Health Care May Worsen Medical Racism* (as of Feb. 8, 2023) ACLU, pp. 1-2.

¹³⁴ Christensen et al., *Medical Algorithms Are Failing Communities of Color* (Sept. 9, 2021) Health Affairs (as of Feb. 8, 2023); Waddell, *Medical Algorithms Have a Race Problem* (Sept. 18, 2020) Consumer Reports (as of Feb. 8, 2023).

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¹⁴⁴ McFarling, *'It was Stolen from Me': Black Doctors are Forced Out of Training Programs at Far Higher Rates than White Residents* (June 20, 2022) STAT (as of Mar. 15, 2023).

¹⁴⁵ Grubbs, *Perspective: Racism in Academic Medicine Is Hindering Progress Toward Health Equity* (Feb. 17, 2023) Cal. Health Care Foundation (as of Mar. 15, 2023).

¹⁴⁶ Compare Cal. Health Care Foundation, *California Physicians* (Mar. 2021) (as of Nov. 28, 2022) with U.S. Census Bureau, *Race* (2020) (as of Nov. 28, 2022).

¹⁴⁷ See Cummings, *Listening to Black Californians: How the Health Care System Undermines Their Pursuit of Good Health* (Oct. 4, 2022) Cal. Health Care Foundation (as of May 19, 2023).

¹⁴⁸ See University of Cal., Office of the President, *UC Programs in*

Medical Education (UC PRIME) (as of Nov. 28, 2022).

¹⁴⁹ Such support is especially crucial given the racial discrimination experienced by African American physicians, which compounds the tremendous stress borne by physicians generally, especially during the COVID-19 pandemic. (See American Medical Assn., *Summary Report: Experiences of Racially and Ethnically Minoritized and Marginalized Physicians in the U.S. During the COVID-19 Pandemic* (2021) (as of Feb. 10, 2023); Serafini et al., *Racism as Experienced by Physicians of Color in the Health Care Setting* (2020) 52 Family Medicine 282, 282-287; see also Berg, *Half of Health Workers Report Burnout Amid COVID-19* (Jul. 20, 2021) American Medical Assn. (as of Feb. 10, 2023) [noting that African American healthcare workers, generally, experienced especially high stress levels during the pandemic].)

¹⁵⁰ See generally Johnson et al., *University of California Programs in Medical Education* (Sept. 2022) Mathematica (as of May 18, 2023).

¹⁵¹ Pfeffinger et al., *Recovery with Limited Progress: Impact of California Proposition 209 on Racial/Ethnic Diversity of California Medical School Matriculants, 1990 to 2019* (Dec. 2020) Healthforce Center at UCSF, pp. 9-10 (see also figures 6 and 7, which chart the change in African American medical students each year, including when UC PRIME programs were created) (as of Nov. 14, 2022).

¹⁵² See Huerto, *Minority Patients Benefit From Having Minority Doctors, But That's a Hard Match to Make* (Mar. 31, 2020) Univ. of Mich. Health Lab (as of Nov. 28, 2022); Williams et al., *Racism and Health: Evidence and Needed Research* (2019) 40 Annual Rev. of Pub. Health 105 (as of Mar. 16, 2022).

¹⁵³ See Chapter 12, Mental and Physical Harm and Neglect.

¹⁵⁴ Such support is especially crucial given the burdens of racial discrimination borne by African American mental health professionals, which contributes to burnout and the lack of African American mental health providers for the African American community, more

generally. (See Shell et al., [Investigating Race-related Stress, Burnout, and Secondary Traumatic Stress for Black Mental Health Therapists](#) (2021) 47 J. of Black Psych. 669, 669 (as of May 18, 2023).)

¹⁵⁵ Cal. Future Health Workforce Commission, [Meeting the Demand for Health](#) (Feb. 2019) p. 30 (as of May 18, 2023).

¹⁵⁶ See generally Johnson et al., *University of California Programs*, *supra*.

¹⁵⁷ See, e.g., Welfare and Institutions Code § 5822; Cal Stat. 2021, ch. 440; Cuevas, [AB 462 – Assemblywoman Wendy Carrillo’s Bill to Expand the Pipeline of Mental Health Professionals – Reaches Governor Newsom’s Desk](#) (Sept. 7, 2021) Wendy Carrillo, Assemblywoman, District 52 (as of Nov. 29, 2022); Cal. Health Care Foundation, [New University of California Program Will Double Pipeline of Specialized Mental Health Providers in Response to Growing Crisis](#) (Jan. 29, 2020) (as of Nov. 29, 2022).

¹⁵⁸ See generally Taylor et al., [Improving and Expanding Programs to Support a Diverse Health Care Workforce](#) (May 2022) Urban Institute (as of Nov. 28, 2022).

¹⁵⁹ See generally See Chapter 12, Mental and Physical Harm and Neglect, at pp. 406-436.

¹⁶⁰ Foundation for Cal. Community Colleges, [California Launches Medicine Scholars Program to Help Diversify the State’s Primary Care Physician Workforce](#) (Jun. 28, 2022) (as of Nov. 28, 2022).

¹⁶¹ *Ibid.*

¹⁶² *Ibid.*

¹⁶³ Taylor et al., *Improving and Expanding Program*, *supra*, at pp. 9-11; see also, e.g., Guerrero et al., [Evaluation of the Pathways for Students into Health Professions: The Training of Under-Represented Minority Students to Pursue Maternal and Child Health Professions](#) (2015) 19 Matern Child Health J. 265 (as of May 18, 2023) (discussing the success of a federal pathway program implemented at UCLA).

¹⁶⁴ See Cal. Future Health Workforce Commission, *supra*, at pp. 7-8.

¹⁶⁵ Taylor et al., *Improving and Expanding Program*, *supra*, at pp. 54-55.

¹⁶⁶ Rogers et al., *Demographics of Disciplinary Action by the Medical Board of California (2003-2013)* (2017) Cal. State Library, pp. 12-15 (as of Nov. 14, 2022).

¹⁶⁷ Medical Bd. of Cal., [Committees, Panels, and Task Forces](#) (as of Nov. 29, 2022).

¹⁶⁸ See, e.g., United States Department of Agriculture Economic Research Service, [Key Statistics & Graphics](#) (as of Jan. 19, 2023); Healthy People 2030, [Food Insecurity](#), U.S. Dep’t of Health and Human Services (as of Jan. 19, 2023).

¹⁶⁹ See Chapter 12, Mental and Physical Harm and Neglect, at pp. 433, 435; see also, e.g., LaVeist & Wallace, Jr., *Health Risk and Inequitable Distribution of Liquor Stores in African American Neighborhoods* (2000) 51 Social Science & Medicine 613; Bower et al., [The Intersection of Neighborhood Racial Segregation, Poverty, and Urbanicity and its Impact on Food Store Availability in the United States](#) (Jan. 2014) 58 Preventative Medicine, pp. 33-39 (as of May 19, 2023); Cooksey-Stowers et al., [Racial Differences in Perceived Food Swamp and Food Desert Exposure and Disparities in Self-Reported Dietary Habits](#) (Oct. 2020) 17 Internat. J. Environmental Research Public Health 19, p. 7143 (as of May 19, 2023); Morland et al., [Neighborhood Characteristics Associated with the Location of Food Stores and Food Service Places](#) (Jan. 2002) 22 American J. of Preventive Medicine 1, pp. 23-29 (as of May 19, 2023); Annie E. Casey Foundation, [Food Deserts in the United States](#) (Feb. 13, 2021) (as of May 19, 2023); Cal. Dept. of Food and Agriculture, [Improving Food Access in California: Report to the California Legislature](#), p. 6 (2012) (as of May 19, 2023).

¹⁷⁰ Subica et al., [The Geography of Crime and Violence Surrounding Tobacco Shops, Medical Marijuana Dispensaries, and Off-sale Alcohol Outlets in a Large, Urban Low Income Community of Color](#) (2018) 108 Preventative Medicine 8, p. 8-15 (as of May 19, 2023).

¹⁷¹ See, e.g., Cooksey-Stowers et al., *Racial Differences*, *supra*, at p. 7143; Univ. of Conn. Rudd Center on Food Policy

and Health, [Food Security](#) (as of Jan. 16, 2023); Choucair, [Healthy New Food Carts: One Step Closer to Eliminating Food Deserts](#) (2014) Chicago Medical Society (as of Jan. 19, 2023); Gundersen & Ziliak, [Food Insecurity and Health Outcomes](#) (Nov. 2015) 34 Health Affairs 11 (as of May 19, 2023); American Diabetes Assn., [Food Insecurity and Diabetes](#) (as of Jan. 16, 2023); American Diabetes Assn., [The Burden of Diabetes in California](#) (Oct. 2021) (as of Jan. 16, 2023); Subica et al., *The Geography of Crime and Violence*, *supra*, at p. 15..

¹⁷² See, e.g., Mukherjee, [Redlining’s Legacy: Food Deserts, Insecurity, and Health](#) (Sept. 28, 2020) Morning Sign Out at UCI (as of May 19, 2023); Eisenhauer, [In Poor Health: Supermarket Redlining and Urban Nutrition](#) (2001) 53 GeoJournal 125, pp. 125-133 (as of May 19, 2023).

¹⁷³ See Chapter 12, Mental and Physical Harm and Neglect, at pp. 433, 435; see also Dutko et al., [Characteristics and Influential Factors of Food Deserts](#) (2012) U.S. Dept. of Agriculture, pp. 3, 11 (as of Mar. 23, 2023); Mitchell, [Liquor Stores, Dispensaries and Smoke Shops: Our Neighborhood is Killing Us](#) (Dec. 8, 2020) KCET (as of Mar. 23, 2023).

¹⁷⁴ Morland et al., [Neighborhood Characteristics Associated with the Location of Food Stores and Food Service Places](#) (Jan. 2002) 22(1) American Journal of Preventive Medicine, p. 23-29 (as of May 19, 2023).

¹⁷⁵ Assem. Bill No. 581 (2011-2012 Reg. Sess.); California State Treasurer, [California Healthy Food Financing Initiative Council](#) (as of May 19, 2023).

¹⁷⁶ Assem. Bill No. 2635 (2016-2017 Reg. Sess.).

¹⁷⁷ Harvard Univ. T.H. Chan School of Public Health, [Improving Food in the Neighborhood](#) (as of May 19, 2023) [citing experts’ recommendations].

¹⁷⁸ *Ibid.*

¹⁷⁹ See, e.g., Assem. Bill No. 889 (2021-2022 Reg. Sess.).

¹⁸⁰ See, e.g., Assem. Bill No. 889 (2021-2022 Reg. Sess.).

¹⁸¹ Food Empowerment Project, [Shame on Safeway and Albertsons: Blocking Access to Healthy Food](#) (as of Jan. 24, 2023).

¹⁸² California Task Force to Study and Develop Reparation Proposals for African Americans (Dec. 7, 2021), Testimony of Bruce Appleyard, <https://oag.ca.gov/system/files/media/task-force-materials-p3-120721-120821.pdf> (as of Mar. 23, 2023); Austin, [To Move is to Thrive: Public Transit and Economic Opportunity for People of Color](#) (Nov. 15, 2017) Demos (as of Mar. 23, 2023).

¹⁸³ See Improving Food in the Neighborhood, *supra* [citing experts' recommendations].

¹⁸⁴ See, e.g., Dutko et al., *Characteristics and Influential Factors of Food Deserts*, *supra*, at pp. 3, 11.

¹⁸⁵ See *Improving Food in the Neighborhood*, *supra* [citing experts' recommendations].

¹⁸⁶ *Ibid.*

¹⁸⁷ *Ibid.*

¹⁸⁸ *Ibid.*

¹⁸⁹ *Ibid.*

¹⁹⁰ *Ibid.*

¹⁹¹ *Ibid.*

¹⁹² LaVeist & Wallace, Jr., [Health Risk and Inequitable Distribution of Liquor Stores in African American Neighborhoods](#) (Aug. 15, 2000) 51 *Social Science & Medicine* 613; DiSantis et al., [Sensitizing Black Adult and Youth Consumers to Targeted Food Marketing Tactics in their Environments](#) (Nov. 2017) 14 *International J. of Environmental Research and Pub. Health* 1316 (as of May 19, 2023).

¹⁹³ Fleming-Milici et al., [Examples of Social Media Campaigns Targeted to Teens and Hispanic and Black Youth](#) (2020) Univ. of Conn. Rudd Center for Food Policy & Obesity (as of Mar. 23, 2023); Lucan et al., [Unhealthful Food-and-Beverage Advertising in Subway Stations: Targeted Marketing, Vulnerable Groups, Dietary Intake, and Poor Health](#) (2017) 94 *J. Urban Health* 220 (as of May 19, 2023).

¹⁹⁴ Lucan et al., *Unhealthful Food-and-Beverage Advertising*, *supra*, at p. 220.

¹⁹⁵ *Ibid.*

¹⁹⁶ *Ibid.*

¹⁹⁷ *Ibid.*

¹⁹⁸ *Ibid.* For examples of incentives and supports that encourage small retailers to offer healthier options such as fresh produce, see Laurison, [Incentives for Change: Rewarding Healthy Improvements to Small Food Stores](#) (2014) ChangeLab Solutions (as of May 19, 2023).

¹⁹⁹ See *Improving Food in the Neighborhood*, *supra* [citing experts' recommendations].

²⁰⁰ E.g., Food Policy Networks, [About Us](#) (as of Jan. 19, 2023).

²⁰¹ See, e.g., Aminetzah et al., [Black Farmers in the US: The Opportunity for Addressing Racial Disparities in Farming](#) (Nov. 10, 2021) McKinsey & Co. (as of May 19, 2023).