

MEND

Policy Report:

Legal analysis, stakeholder insights, & policy recommendations for healthcare provider implicit bias training in California



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INTRODUCTION

On October 7, 2019, Governor Newsom signed the “**California Dignity in Pregnancy and Childbirth Act**” (**SB 464**), making California one of the first states to pass a law requiring implicit bias training for perinatal providers.^a The law is intended to respond to widespread concern regarding maternal mortality in the United States, particularly among women and birthing people of color. Most maternal deaths are preventable, yet they have been increasing in the U.S. since 2000.¹⁻³ In fact, the U.S. has the highest maternal mortality rate among high-income countries.^{4,5} In 2018, there were 17 maternal deaths for every 100,000 live births in the U.S.—a ratio more than double other high-income nations (e.g., Germany, Japan).⁴ By 2021 the US rate was nearly three times that of high-income countries overall.^{5,6}

Looking at these trends for mothers and birthing people by race and ethnicity illustrates an even more devastating picture. In the U.S., Black women and birthing people are 3.5 times more likely to die from a pregnancy-related cause than white women and birthing people; and experience significantly higher rates of preeclampsia, preterm birth, and neonatal mortality.^{1,7-9} The COVID-19 pandemic has made these rates even worse.^{10,11} Black women and birthing people’s elevated risk for maternal mortality, morbidity, and preterm birth exists across the socioeconomic spectrum.^{8,12} Women and birthing people of color additionally report higher rates of mistreatment during pregnancy and birth than their white counterparts;¹³⁻¹⁵ and report disrespectful and disempowering interactions with perinatal care providers in studies across diverse geographic regions and clinical settings.^{14,16-18} Black women and birthing people in the US often experience obstetric racism,^{19,20} describing the amplified harms of racism in the obstetric context.

Although California’s overall maternal mortality rate improved over the past two decades and in recent years has been about a third of the national average, it has seen recent increases linked to COVID-19.^{21,22} Additionally, the state’s racial inequities in maternal mortality persist.^{21,23} The pregnancy-related mortality rate of Black women and birthing people is four times that of their white counterparts.²⁴ Experts agree that multiple strategies are necessary to eliminate these racial disparities.²⁵⁻²⁸

The “California Dignity in Pregnancy and Childbirth Act” (hereinafter “SB 464” or “the Act”) primarily targets implicit bias at the interpersonal level (e.g., provider-patient) by requiring implicit bias training of perinatal providers and disclosures to patients of their right to nondiscriminatory care.²⁹ It also attempts to improve the reporting of maternal deaths. This legislation comes at a particularly fraught moment in California, with proponents concerned about a combination of logistical, legal, and philosophical barriers to its implementation. The public has become aware of these inequities and their structural roots and is calling for measures such as SB 464 – in addition to system-level changes – to redress racial health disparities. Examining barriers to and the mechanics of SB 464 is crucial to helping the legislation meet its goal of eliminating maternal mortality in California.

This report aims to describe the background and current implementation of SB 464, as well as perceptions and recommendations regarding the law from patients and providers. **Part I** reviews the scientific literature informing the need for SB 464. **Part II** examines the various elements of the law, the legislative history of the bill, and the state of the law prior to the passage of SB 464. **Part III** describes what is known about the implementation status of SB464’s implicit bias training requirement. **Part IV** describes findings from our own mixed-methods study examining insights of key stakeholders of SB 464—Black women whom it intends to benefit, and perinatal care providers who will take the training—regarding challenges, opportunities, and recommendations for the required antibias training. **Part V** provides synthesis and actionable recommendations for policymakers and other stakeholders to support the implementation and effectiveness of clinician implicit bias training in California.

a. Implicit bias refers to prejudicial attitudes towards and stereotypical beliefs about a particular social group or members therein. “Perinatal care” is the provision of care during pregnancy, labor, delivery, and postpartum and neonatal periods.

Similar to many proponents of SB464,³⁰ the MEND study team recognizes that implicit bias training—an individual-level intervention focused on intra- and interpersonal bias and racism—is just one piece of the multi-level, multi-pronged changes required to reduce inequities in maternal health. We urge readers—including policy-makers, healthcare leaders, and funders—to also learn about and support system-level interventions³¹ designed to reduce structural racism and its effects on maternal health. Examples include community power-building,^b new models of pre- and perinatal care,^c transforming community-hospital relationships,^d and enriching the maternity care workforce.^e

Scholarly references cited below are linked to entries in the References section of the report (page 20). Footnotes are used to present supplementary content and to provide detailed legal references to specific aspects of bills, state law, and similar resources.



I. THE PROBLEM OF RACIAL DISPARITIES IN MATERNAL MORBIDITY AND MORTALITY

As has been described thoroughly elsewhere, rates of maternal mortality and morbidity in the US are worse than its peer countries' and has worsened in recent years.^{3,10,11} Between 2018 and 2021, the number of maternal deaths increased from 658 (17.4 per 100,000) to 1205 (32.9 per 100,000).¹¹ Scholars have estimated that for each maternal death, approximately 100 women and birthing people experience the serious injuries referred to as maternal morbidity.³² The CDC recently concluded that more than 80% of pregnancy-related deaths in the US were preventable.³³ Due to the legacies of structural and interpersonal racism, Black and Indigenous women and birthing people nationally, as well as other racial and ethnic groups in certain US regions, bear a disproportionate burden of maternal and pregnancy-related mortality.⁹ COVID-19 has exacerbated these disparities, increasing the maternal mortality rate for Black and Hispanic women and birthing people, in particular.^{5,10,11} As of 2021, nearly Black women and birthing people had a maternal mortality rate 2.6 times higher than their white counterparts.¹¹

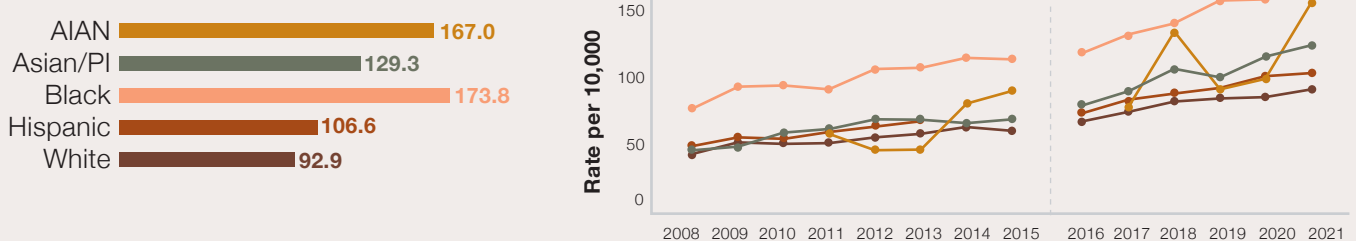
California has made important strides in addressing maternal mortality.^{21,22,34} However, significant racial disparities persist.^{23,24} As of 2020, the most recent publicly-available data, Black women and birthing people in California experienced more than 3 times the rate of pregnancy-related mortality compared to white women and birthing people (Figure 1). Data from 2021 reveal they experienced nearly double the rate of severe maternal morbidity (Figure 2).^{21,24,35} These rates likely worsened during the pandemic, as they did nationally.^{10,11}

Figures from California Pregnancy Mortality Surveillance System Data Dashboards

Figure 1. Pregnancy-related Mortality Ratio by Race/Ethnicity, California, 2018-2020



Figure 2. Severe Maternal Morbidity by Race/Ethnicity, California, 2021



In addition to inequitable clinical outcomes, we know that Black women and other people of color are also inequitably burdened by experiences of suboptimal health care. For example, studies have also shown that healthcare providers are more likely to underestimate pain levels reports by Black patients,³⁶ more likely to conduct illicit drug tests on Black parents and their newborns,³⁷ less likely to prescribe pain medication,³⁸ and less likely to recommend clot-reducing medication to Black patients as opposed to white patients.³⁹ Research has also specifically documented the impact of social determinants, racism, and chronic stress on maternal and infant health outcomes.^{40–42}

Importantly, even when controlling for insurance status, income, age, and severity of conditions, people of color are less likely to receive routine medical procedures and experience a lower quality of care.⁴³ This pattern holds for maternal health as well, where studies have found that racial disparities persist across education levels. A Black mother with a college education is at 60 percent greater risk for a maternal death than a white or Hispanic woman with less than a high school education.³ In fact, mortality ratios for white mothers decrease with higher education, but the difference in mortality risk for a Black mother with less than a high school education and one with a college degree is minimal.³ A large study using linked health and income administrative records data from California echoed these findings, concluding that “infant and maternal health in Black families at the top of the income distribution is markedly worse than that of white families at the bottom of the income distribution.”^{44,45} Similarly, socioeconomic status does not explain inequities in pre-eclampsia or gestational length⁸ or in preterm birth.¹² The disproportionate burden of maternal mortality and morbidity that Black women and birthing people shoulder cannot be explained by socioeconomic factors.

Black women and birthing people additionally experience the burdens of disrespectful care and obstetric racism, such as not being listened to or being pressured to undergo procedures.^{13,14,17–19} In recent years, research and news reports have raised attention to the effects of provider bias during pregnancy and delivery.^{46–48}

In one study, Indigenous, Hispanic, and Black women reported significantly higher rates of mistreatment (such as shouting and scolding, ignoring or refusing requests for help) during their pregnancy.¹⁴ A survey study in California focusing on Black mothers found that participants were more likely to report explicit discrimination from birthing staff, barriers in communication with healthcare providers, or disregard from delivery staff for their birthing wishes during their perinatal and postpartum healthcare interactions.⁴⁸ In a large qualitative study, participants identified four sets of practices and attitudes that led to conflict between medical staff and Black pregnant women:

- 1. refusal to listen to women’s wisdom about their bodies;**
- 2. not respecting women’s boundaries**
- 3. stereotyping based on race, class, age, sexual orientation, and marital status, and**
- 4. suppressing advocacy and self-advocacy.⁴⁹**

Consistent with these bodies of research, scholars have pointed to the importance of recognizing interpersonal bias and racism—alongside structural racism—as key drivers of inequities in maternal health care and outcomes.^{19,26,28,50,51} Accordingly, reducing bias and racism are crucial steps in combatting maternal health inequities.^{26,27,50,52} Though the evidence base connecting antibias training and more equitable clinical care is nascent, leading scholars support it as one of multiple interventions needed to curb the maternal health crisis in the US.^{26,27,53,54}

b. <https://www.nwjf.org/en/building-a-culture-of-health/focus-areas/Features/building-community-power-to-advance-health-equity.html#2>
c. <https://www.alamedahealthsystem.org/family-birthing-center/black-centering/> ;
<https://womenshealth.ucsf.edu/coe/embrace-perinatal-care-black-families>
d. <https://www.cherishedfutures.org/>
e. <https://midwifementoring.ucsf.edu/>

II. OVERVIEW OF THE CALIFORNIA DIGNITY IN PREGNANCY AND CHILDBIRTH ACT

The California Dignity in Pregnancy and Childbirth Act was introduced into the California legislature as SB 464 by Representative Holly Mitchell with these exact aims in mind. In doing so, she emphasized, “[b]y preparing perinatal medical providers to better care for mothers in some of the most vulnerable moments in their lives, this bill will preserve lives so that childbirth remains a joyful moment for all mothers, and not a life-threatening event for Black mothers.” The bill passed the California Assembly and Senate unanimously and includes specific legislative findings as to the persistence of racial disparities in birth outcomes and the research evidence linking those outcomes to implicit bias. The legislature found that “Implicit bias is a key cause that drives health disparities in communities of color.”^g

The bill received support from ACT for Women and Girls, Black Women for Wellness, NARAL Pro-Choice California, Western Center on Law and Poverty, and the California Nurse-Midwives Association.^h The only key opponent to the bill was the California Medical Association (CMA), which noted that it would oppose the bill unless certain amendments were made to the implicit bias training requirements. Beyond the CMA, other groups shaped key aspects of the legislation while the bill was in committee, as we will discuss in this section. The enacted legislation aims to address disparities in health outcomes for Black women and birthing people through three primary mandates:

A. Implicit Bias Training

Prior to the passage of the Act, no California law required training specifically on the impact of implicit bias on the provision of health care. Pre-existing law required that continuing education (CE) courses for physicians in California include a discussion of “cultural and linguistic competency” in the practice of medicine, but that requirement does not encompass the content envisioned in SB 464 and applies only to physicians.ⁱ The Act represents a unique approach in that it adds content requirements, applies to providers beyond just physicians, and is a direct mandate on certain health care facilities and providers, circumventing the California professional boards that normally develop, monitor, and enforce such requirements.

1. Covered Providers

The Act requires hospitals,^j licensed alternative birth centers,^k and primary care clinics offering alternative birth center services^l to provide evidence-based implicit bias training to all clinicians involved in perinatal care at those facilities.^m Each provider must complete an initial training followed by a refresher training at least every two years. Facilities may elect to train more frequently as may be deemed necessary. Providers must complete an implicit bias training in addition to their other continuing education requirements. Notably, because the development and implementation of this training occurs at the facility-level, it seems to operate outside of continuing education processes normally overseen by the Medical Board of California, the Board of Registered Nurses, and the Physician Assistant Board. Indeed, there is no requirement in the Act that such boards have any involvement in implicit bias training, including monitoring and/or enforcing training completion.

Additionally, because the law operates through a mandate on facilities regulated as hospitals, there may be limitations as to its reach and enforceability. The California Senate Health Committee identified in its bill analysis that, while there are exceptions, under California law, physicians are generally not “employees” of a hospital and are instead “contractors”.ⁿ The hospital’s medical staff, which is a different legal entity than the hospital and its governing board, determine whether or not to grant hospital privileges and under what conditions

i. CAL. BUS. & PROF. CODE § 2190.1.

j. Defined in subsections (a) and (f) of CAL. HEALTH & SAFETY CODE § 1250.

k. Per statute “[a]n “alternative birth center” means a clinic that is not part of a hospital and that provides comprehensive perinatal services and delivery care to pregnant women who remain less than 24 hours at the facility.” CAL. HEALTH & SAFETY CODE § 1204.

l. CAL. HEALTH & SAFETY CODE § 1204.3.

m. CAL. HEALTH & SAFETY CODE § 123630.3.

(e.g., contracting with a physician). The Committee believed that this would limit a hospital's ability to require physician compliance with the law. To address this issue, the Committee suggested that the bill's author consider adding a provision specifically mandating hospital medical staff boards to condition hospital privileges on completion of implicit bias training for physicians providing perinatal care.^o This provision was not adopted, and weaker language was used instead, requiring facilities to simply "offer" the training to physicians not directly employed by the facility.^p However, if such training is not a clear requirement of hospital privileging, a hospital may have limited ability to enforce the training mandate among its contracted physicians.

Finally, the Act also does not apply to providers of any kind at free-standing birth centers or to those providing assistance with home-based births. This was criticized as a major gap by the California Midwives Association.^q The law also does not apply to prenatal care providers or to staff or other providers not directly involved in perinatal care.

A likely effect of these provisions is that some, but not all, providers a Black woman or birthing person encounters during the course of pregnancy and delivery will have been required to take implicit bias training, and those most likely to have taken it will be non-physician employees of a hospital-based facility where delivery occurs.

2. Training Content

In addition to describing which facilities must offer implicit bias training and which providers must take part, the Act also outlines the content that must be included in the training. The Act requires ten components of implicit bias training programs:

REQUIRED TRAINING COMPONENTS

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

n. California Senate Committee on Health, California Dignity in Pregnancy and Childbirth Act, California Legislature (Apr. 8, 2019), https://leginfo.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201920200SB464. Note that the CMA also argued that the training requirement was not an appropriate or enforceable mechanism for training physicians and that it preferred such a requirement flow through continuing education requirements, such as in AB 241 introduced by Assemblymember Kamlager-Dove. AB 241 was ultimately passed, though its content requirements are narrower and less developed than those outlined in SB 464, leaving much to the discretion of the content provider.

o. California Senate Committee on Health, California Dignity in Pregnancy and Childbirth Act, California Legislature (Apr. 8, 2019), https://leginfo.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201920200SB464.

p. California Senate, Senate Floor Analysis of California Dignity in Pregnancy and Childbirth Act, California Legislature (Sept. 9, 2019), https://leginfo.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201920200SB464.

q. California Senate Committee on Health, California Dignity in Pregnancy and Childbirth Act, California Legislature (Apr. 8, 2019), https://leginfo.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201920200SB464.

The Act does not expound on what each of these categories requires in practice, leaving significant room for interpretation. For instance, it is unclear how “previous or current unconscious biases” should be “identified” in a program. Facilities might interpret this provision to mean that individual participants must be asked to reflect on and identify their own biases, or that a facility must provide participants with its own facility-level data on complaints of bias in order to identify trends in biased care, or that academic papers and national studies describing prevalence and types of bias in health care may suffice to surface the existence of bias generally. The Act does not designate a state or professional entity to interpret these requirements and ensure their consistent implementation on a statewide basis, thereby seeming to permit highly varied approaches to training across the state. The Act’s requirement that IBT programs be “evidence-based” likely serves to constrain interpretation here if evidence shows that a particular approach is more effective than others. At present, however, evidence as to the comparative effectiveness of implicit bias training approaches and content in health care settings is lacking. Researchers have produced limited evidence about how implicit bias training can reduce Black maternal mortality. Studies to date suggest implicit bias training has modest and sometimes short-lived effects on individuals’ attitudes and biases.^{46,55,56} Researchers have published little evidence that implicit bias training changes providers’ clinical practice.^{46,57,58} It is therefore unknown whether IBT will affect its intended outcomes or what approaches may maximize its impact.

Two to three main vendors of implicit bias training have been endorsed by health policy leaders (e.g., [California Maternal Quality Care Collaborative](#) [CMQCC],⁵⁹ the [California Health Care Foundation](#) [CHCF],⁶⁰ [Kaiser Permanente](#)⁶¹) and/or seem to be widely-adopted by hospitals (see section III). There may be little appetite or bandwidth among individual facilities to create their own content outside of these pre-existing programs. These training programs are online and asynchronous, requiring no engagement between facility providers and delivering no localized data to participants as to trends in biased care or outcomes at their facilities. Whether large scale implementation of these programs is consistent with the intent of the Act remains to be seen. Further, it is unclear whether any data regarding training implementation and outcomes will be publicly available to assess the trainings’ effects.

3. Oversight and Enforcement

The Act does not designate any state agency to oversee development of the trainings, nor does the Act require any state agency to proactively monitor or enforce compliance with this requirement. Facilities must provide a certificate of training completion to providers who request it and must accept certificates of completion from other facilities but are not required to regularly report certificate or completion data to any state agency.⁵ This lack of data-gathering around IBT implementation and outcomes is particularly notable given that the Act itself requires an evidence-based approach to training, and elsewhere in the Act efforts are made to enhance data reporting around racial disparities in birth outcomes.

The Act had three other provisions beyond the IBT requirement, which we overview briefly below (Sections B-D). As these aspects of the Act were outside of the scope of the MEND study, we cannot provide insights about their implementation nor their reception by patients or healthcare providers. More detail about the Act’s provisions to improve data reporting on maternal mortality may be found in the Appendix.

B. Informing Patients of Right to Nondiscriminatory Care

Prior to SB 464, hospitals were required to provide admitted patients with information on certain rights such as the right to participate actively in their own health decisions.¹ Patients who experienced a violation of their rights could complain to the California Department of Health (CDPH), the California Department of Fair Employment and Housing (CDFEH) (now called the California Civil Rights Department),⁶² and the Medical Board of California. However, hospitals were not previously required to provide information about these complaint procedures to patients, who had to learn about them on their own.

The Act now requires all hospitals to provide patients with written information on their right to be free from discrimination upon admission.^u Hospitals must also provide information on how to file a complaint with CDPH, the California Civil Rights Department, or the Medical Board of California if patients experience discrimination while receiving care.

C. Improving Data Reporting on Maternal Mortality - Updating the Death Certificate System

SB 464 contains two provisions aimed at improving data reporting on maternal mortality in California. The first provides a statutory update requiring the California Electronic Death Recording System (CA-EDRS) to mirror the U.S. Standard Certificate of Death.^v These changes to CA-EDRS capture more detailed information about when a patient was pregnant in relation to the time of death. California previously only recorded whether a woman was pregnant in the year before death but did not distinguish when within that year. The new data elements include whether a woman was not pregnant in the last year, pregnant at the time of death, pregnant within 42 days of death or 43 days to one year of death, or whether that information is unknown.

D. Improving Data Reporting on Maternal Mortality - Maternal Mortality and Morbidity Tracking and Reporting by CDPH

The second provision requires that CDPH track and publish data on maternal morbidity and mortality.^w With the passage of SB 464, CDPH is statutorily responsible for tracking data on severe maternal morbidity, including conditions such as obstetric hemorrhage, hypertension, preeclampsia and eclampsia, venous thromboembolism, as well as other obstetric complications. The new law then requires CDPH to publish the data they have accumulated every three years. When publishing the data, the law requires CDPH to aggregate the data by state regions but also empowers CDPH to determine if smaller regions would be more appropriate to best reflect how regionalized care systems are or should be collaborating to improve maternal health outcomes, as long as the regions do not risk confidentiality or other disclosure breaches. SB 464 also requires CDPH to disaggregate the data by race and ethnicity.

By passing SB 464, the California legislature intended to address the inadequacies within California law. Instituting implicit bias training for perinatal care providers and taking measures to ensure that state agencies and patients have the information about outcomes and patient rights that they need may help California to collectively address inequities in maternal health care and outcomes.

r. CAL. HEALTH & SAFETY CODE § 123630.3.

s. CAL. HEALTH & SAFETY CODE § 123630.3.

t. See CAL. HEALTH & SAFETY CODE § 1262.6.

u. Specifically, a patient's right to be free of discrimination on the basis of race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, sexual orientation, citizenship, primary language, or immigration status. CAL. HEALTH & SAFETY CODE § 1262.6

v. CAL. HEALTH & SAFETY CODE § 102875.

w. CAL. HEALTH & SAFETY CODE § 123630.4.

III. STATUS OF IMPLICIT BIAS TRAINING IMPLEMENTATION

A 2021 report published by the California Preterm Birth Initiative provided an early investigation of the status of implementation among hospitals and other covered facilities.⁶³ The author distributed a survey to California hospital-based perinatal healthcare providers in early 2021 about the implementation of IBT at their hospitals. The author received 14 responses representing 12 hospitals across four counties. Of the 14 respondents, half worked at a hospital that by that time had implemented IBT required under SB 464. The other half responded that their hospital had not yet implemented SB 464-compliant training. Of the respondents who worked at hospitals that had implemented IBT, the majority said that most or all of their providers had participated in the training. Study respondents shared a wide range of ideas, early in the Act's implementation, about barriers to implementation such as burnout of healthcare workers, lack of awareness of the requirements, resistance to the training, lack of clarity around who should create and facilitate trainings, and the lack of formal oversight, enforcement or incentive measures for hospital and clinics to implement training.⁶³

Since that time, major nongovernmental healthcare players (e.g., CMQCC, CHCF, Kaiser) have endorsed or publicized their use of one of three online asynchronous training modules from [Diversity Science](#), March of Dimes, and/or the [U.S. Department of Health and Human Service Office of Minority Health's Culturally and Linguistically Appropriate Services \(CLAS\) in Maternal Health Care](#).⁵⁹⁻⁶¹ In recent years we perceived that these curricula were widely used by hospitals to fulfill SB464 requirements but had no state-level data to confirm this.

In August of 2021, the California Attorney General (DOJ) sent a letter to all perinatal health facilities requesting specific information about compliance with SB 464.⁶⁴ The letter requested that the facilities provide information regarding any IBT that had already been completed, lists of attendees at each training, the written training materials used, a list of providers who had not yet taken a training, future plans for IBT at their facility, and a description of any other efforts to reduce implicit bias among providers at their facility. In October 2023, the DOJ [released](#) a report describing IBT completion data it had collected through mid-2022 on 242 facilities. The report is worth reading in full. Highlights include: 17% of covered facilities had fully trained all relevant staff; 76% of covered facilities had achieved partial training (average ~77% of relevant staff); and Diversity Science was the dominant training approach used. The DOJ report recommends enhancing transparency, accountability, and incentives to improve facility IBT completion rates. To our knowledge, the DOJ has not brought enforcement actions among hospitals and other covered facilities for not meeting SB464 requirements.

IV. ORIGINAL RESEARCH: PATIENT AND PROVIDER VIEWS ON CHALLENGES, OPPORTUNITIES, AND RECOMMENDATIONS FOR SB464 IMPLICIT BIAS TRAINING (IBT)

Recognizing that existing scholarship did not provide a sufficient evidence base to inform the design or implementation of IBT, and that the law contains few details for how to implement or evaluate the IBT it mandated, an interdisciplinary team at UC San Francisco convened to conduct stakeholder-engaged research that could guide these efforts. Such stakeholder engagement is a core feature of implementation science research, and is an approach that the national health policy community increasingly recognizes as a key component of health services research and implementation.⁶⁵⁻⁶⁷

A group of community experts, social science researchers (UC San Francisco, UC Davis), and legal scholars (UC Law, San Francisco), we launched the **MEND study—Multi-Stakeholder Engagement with State Policies to Advance Antiracism in Maternal Health**—in early 2021. We engaged key stakeholders in research — the Black women and birthing people whom SB464 was designed to benefit, and the perinatal clinicians who would engage in IBT — to understand the challenges and recommendations for designing and implementing impactful clinician IBT. The study was directed by Sarah Garrett, PhD, and funded by UCSF's California Preterm Birth Initiative. Dr. Garrett additionally received support from the Agency for Healthcare Research & Quality (AHRQ; T32HS022241) and the National Institutes of Health (NIH; KL2 TR001870).

A. Approach & methods

MEND was a multi-method community-based participatory research study in the San Francisco Bay Area. Our research explored how SB464 aligned or misaligned with stakeholder realities and priorities in order to generate evidence-based recommendations to inform local policy and state law implementation. All activities were guided by a community advisory panel of individuals who were themselves IBT stakeholders. They identified as mothers and women who identified as Black, Black and Latina, or Black and American Indian.

- In Fall-Winter 2021, we conducted focus groups and surveys with **20 Black women who had a hospital birth in 2020 or 2021**. Most had Medi-Cal insurance coverage; found it “somewhat” or “very hard” to pay for basic needs; and delivered in a safety-net or managed care setting in 2020-2021. All identified as Black women.
- In Fall 2021 – Spring 2022, we conducted in-depth interviews and surveys with **20 multidisciplinary perinatal clinicians** who worked in community or safety-net hospitals. These clinicians were nurse midwives (6), physicians (6), registered nurses (5), or other staff (3). They self-identified as Black (4), multiracial (4), or white (12) women; two identified as Latinx or Hispanic.
- The study was reviewed and approved by the UCSF Institutional Review Board (#21-33289).

All data collection was conducted and/or closely advised by the study’s principal investigator. Numerous steps were taken to promote rigor and validity, including orienting all research participants to SB464 and its requirements. Iterative inductive and deductive thematic analysis was conducted to identify, categorize, and describe challenges and recommendations for effective IBT. We categorized resulting themes into levels that correspond with different stakeholder groups who would act on the findings (e.g., state policymakers, health facility leaders, providers).

B. Findings

Overall, patients and clinicians had concerns about whether clinician implicit bias training could produce better care and clinical outcomes. They identified challenges related to the law (SB464), the training, healthcare facilities, and clinician learners. However, they supported IBT’s use and identified many ways to maximize its effectiveness.

Patient and clinician insights overlapped substantially with the following exceptions: Patients focused more than clinicians on state policy change (e.g., IBT funding, intensity of training) and on the importance of accountability and enforcement in both state law and within health systems. Clinicians focused more than patients on facility-based considerations such as IBT logistics, IBT format, selection of IBT trainers, and clinic culture.

We describe the challenges, support, and recommendations identified by MEND participants below. For more detail, including methods, participant quotations about these topics, and greater detail about hospital-level implementation, please see the *Health Equity* article [here](#), coauthored by MEND community and academic study collaborators.

Numerous challenges to IBT advancing birth equity

Drawing on their lived experiences as patients or perinatal providers, respondents identified numerous challenges to the implementation and effectiveness of IBT that they either anticipated or observed. Participants raised these when asked about how or why IBT may fail to improve care or clinical outcomes for Black women and birthing people. We summarize these on four levels:

STAKEHOLDER-IDENTIFIED CHALLENGES TO IBT

- **Scope and Nature of State Law** - Concerns focused on limitations of the Act, such as inadequate training frequency, enforcement, and scope of providers included (e.g., not including prenatal care clinicians); as well as insufficient detail as to the level of training intensity required, allowing for the use of potentially ‘superficial’ trainings.
- **Implicit Bias Training Content and Format**- Concerns centered on the content of training being insufficiently rich, nuanced, or relevant to different settings; and that it may not sufficiently engage providers to foster self-reflection and recognition of own biases. Participants also critiqued IBT with non-interactive formats, particularly individual, online self-administered formats, and the lack of opportunities for applied skills-building or ongoing learning. Many respondents questioned the power of IBT to change deep-seated biases, particularly if delivered in online-only solo learning modules (“just a check-box”).
- **Provider commitment and actions** – Concerns centered on providers having low levels of motivation, commitment, or openness to IBT--particularly that those “who need it the most” may not take the training seriously. Respondents were concerned that some providers would not recognize their own biases or a need to change, and could even become defensive or react negatively.
- **Health facility environment and culture** - Concerns centered on challenges of implementing IBT (e.g., regarding time constraints, provider busyness, lack of resources, selection of ineffective trainers); the lack of accountability/enforcement for IBT participation; and the absence of efforts to evaluate IBT effectiveness. Concerns also focused on leadership missteps, e.g., selection of poor curriculum or trainers; inadequate leadership support of antibias efforts; on limited opportunities for ongoing antibias leaning; and on clinic culture that discourages frank discussion about racism and bias.

Many participants additionally expressed the overarching concern that IBT would not improve outcomes without concurrent system-level interventions (e.g., greater racial/ethnic workforce diversity; more comprehensive supports for pregnant, parenting, and postpartum individuals).

Substantial support for SB464 IBT among MEND participants

Despite the concerns they shared, MEND study participants were supportive of SB464’s required training. Nineteen of the 20 clinician participants agreed or strongly agreed that they personally wanted to take SB464 implicit bias training. Similarly, 19 of 20 Black mother participants (“patient participants”) agreed or strongly agreed that they wanted their providers to take SB464 implicit bias training. Patient participants additionally endorsed the 10 topic areas of SB464 IBT (described in Section II A(2)). Each was described by 18 or more of 20 patient respondents as “somewhat” or “very important,” with “very important” the modal response for each topic. As one focus group participant said, “I feel like the list was great... From history to the community, like, it was perfect. I’m like, ‘Okay, somebody understood the assignment.’”

Actionable recommendations to optimize IBT

We asked participants to reflect on the facilities where they worked or received healthcare to consider what could help to make IBT more able to improve care and clinical outcomes for Black women and birthing people. We summarize these on four levels, described on the following page. We note that MEND participant recommendations regarding the scope and nature of state law align with recommendations presented in the Department of Justice’s recent [report](#) on SB464 training completion in California.

STAKEHOLDER RECOMMENDATIONS FOR IBT

- **Enhancing the Scope & Nature of State Law** — Participants recommended creating clear and effective enforcement mechanisms; expanding the scope, intensity, and funding of IBT; mandating IBT for the entire maternity healthcare workforce; and creating accountability for improved patient care and outcomes. The latter was a particularly high priority for patient respondents.
- **Enhancing Implicit Bias Training Content & Format** — This included enhancing content by including, for example, data customized to each facility (e.g., data on inequities at the learner's own hospital); real patient stories (e.g., about the experience of biased care); and about the history of racism in U.S. Many participants recommended the use of interactive synchronous training formats that could support reflection and dialogue, as well as ongoing applied antibias skills-building.
- **Encouraging Provider Commitment & Actions** — MEND participants urged those taking IBT to engage training seriously and with an open mind, and to reflect on and recognize their own biases. Participants recommended that healthcare workers participate in supplemental training if they receive complaints of biased behavior.
- **Creating a Favorable Healthcare Facility Culture & Environment** — This included fostering safe spaces for ongoing learning and discussion; easing logistics to facilitate healthcare workers' focused participation; enhancing the legitimacy of IBT by engaging respected facility champions and trainers; and creating accountability systems to support IBT participation and reductions in biased care. Many MEND participants felt that IBT would be most impactful when paired with complementary equity-focused interventions in the facility (e.g., workforce diversification).

We share full, specific recommendations as a checklist and discussion guide for hospital-based teams. The document is downloadable [here](#).

Recommendations have support outside of the Bay Area as well

The findings described above are from the main MEND study – a rigorous multi-methods social science research project with participants from the San Francisco Bay Area. To begin to evaluate whether the main study findings were relevant for stakeholders outside of our study region, we conducted additional preliminary research.

At a September 2022 birth equity-focused online “town hall” with over 100 attendees, the MEND study fielded a short survey designed to investigate whether individuals outside of the MEND recruitment region agreed with a collection of MEND study-derived IBT recommendations.

Healthcare worker respondents past and present (n=54), as well as non-healthcare worker respondents (n=24), recorded high levels of support for the recommendations queried. Levels were similarly high both within and outside of the main MEND Bay Area recruitment region.

For the full presentation of methods, sample, findings, limitations, and implications, please see the report [here](#).

V. SYNTHESIS AND POLICY RECOMMENDATIONS

Given the research findings described in section IV and, our own analysis of the Act, and the DOJ's recent [reporting](#) of incomplete training in most of California's covered facilities, we believe further action is needed to ensure that the law is implemented in a manner consistent with its stated intent. As described above, the legislation enjoys broad support from key stakeholders in principle, but key barriers and gaps threaten its meaningful implementation. Key gaps and barriers we identified include:

1. Scope and Nature of the Legal Mandate, including the lack of an entity responsible for the monitoring or enforcement of the required training; the lack of guidance regarding practical details of the training and its implementation (e.g., minimum level of intensity); and lack of funding or technical support for hospitals' selection, implementation, and evaluation of the training.
2. Limitations of existing evidence base, which presents a challenge for IBT developers and for hospital leaders, who would wish to evaluate and identify the most promising trainings. In the absence of evidence regarding what IBT content, format, and implementation strategies improve clinical outcomes for affected populations, stakeholder insights provide important early guidance.
3. Widely used IBT approaches do not currently align with key stakeholder recommendations. This is evident in, for example, the widespread use of solo, self-administered online trainings—which many MEND participants felt would not lead to change in deep-seated biases—and the lack of state-level supports or accountability mechanisms.
4. The law focuses primarily on addressing interpersonal bias and racism, with little attention to the institutional and system factors that can both harm patients and limit the implementation and impact of equity-focused interventions such as IBT.

Primarily, we recommend the creation of a state task force to conduct initial coordination and oversight of implementation efforts. This body would be tasked with gathering information and data to provide recommendations to the state regarding four aspects of IBT implementation: 1) evidence-based practices for design and implementation of IBT curriculum and related quality improvement efforts; 2) initiatives to foster transparency around IBT implementation and outcomes; 3) strategies to incentivize and enforce IBT requirements; and 4) designation of a state agency for long-term oversight of implementation and enforcement of the goals of SB 464. We describe each of these action steps below.

A. Creation of State Task Force

The law as currently written does not designate an entity responsible for coordination or oversight of SB 464 implementation. This lack of oversight has raised significant concerns regarding the efficacy of the law. Other states implementing IBT initiatives have designated a task force or specific state agency to coordinate, study, and oversee such efforts.^x (See **Resource A**, below, for a state-by-state overview.) To address this gap, we recommend that the legislature create and fund such a task force. To ensure efficacy and community-responsiveness, the task force should consist of members of affected communities, specifically Black women and birthing people who are named as intended beneficiaries of SB464, community-based organizations, hospitals and alternative birth centers serving Black women and birthing people, members of the birth equity research community, and other stakeholders. The legislature should consider drawing from the California Pregnancy-Associated Review Committee, created by SB65, to the extent the members may fulfill these criteria. The task force would be charged with developing recommendations in the following four areas: 1) evidence-based practices for the design and implementation of IBT curriculum and related quality improvement efforts, 2) initiatives to foster transparency around IBT implementation and outcomes, 3) strategies to incentivize and enforce IBT requirements, and 4) designation of a state agency for long-term oversight of SB 464 implementation. To do this, the task force should be authorized to collect data by, among other things, commissioning studies, holding hearings, and requesting the production of evidence.

As entities of this type are generally convened for a set period of time to produce recommendations, the task force should also be responsible for recommending a state agency that will be responsible for the long-term oversight of the IBT requirement and outcomes. The ultimate goal should be that the task force will be able to pass their findings and data to the state agency so the agency can implement the recommended policies and oversee them indefinitely.

B. Community-Responsive and Evidence-Based Curriculum and Quality Improvement Initiatives

The law requires that IBT curriculum be “evidence-based,” but the evidence for such programs in California is nascent, and early training programs have prompted concerns from patients and providers about the efficacy of IBT content and format. A state task force should be empowered to investigate and recommend best practices for evidence-based IBT curriculum and related quality improvement initiatives. The task force would need to work with hospitals and other covered facilities and gather other data to examine 1) the content and format of currently offered IBT programs, 2) which programs are currently used by facilities and providers, and 3) outcomes associated with various content and formats of trainings. These outcomes should include provider practice change and facility-level patient clinical and experiential outcomes.^z

Additionally, because SB 464 is being implemented alongside another implicit bias training mandate (AB 241), in conducting the above work the task force should coordinate with the Medical Board, Nursing Board, and Physician Assistant Board. These Boards are tasked with oversight and implementation of implicit bias training beyond just perinatal providers. A failure to coordinate these efforts may lead to missed opportunities to understand best practices, duplication of efforts, and/or confusion regarding compliance.

C. Fostering Transparency of IBT Implementation and Outcomes

The law currently does not require any entity to report to the public the status of IBT implementation or its effectiveness. However, stakeholders indicate a desire to see that this law is taken seriously and has a positive effect on maternal health outcomes. The task force should therefore initiate efforts to enhance public access to information regarding both IBT implementation and outcomes.

Among many possible approaches to this goal, we suggest two: 1) integrating IBT implementation into facility quality measures that are publicly available and 2) tracking complaints of discrimination as a new separate category of complaints on the California Medical Board and California Department of Public Health websites.

To address the first approach of integrating IBT into hospital quality measures, the task force could work with California’s Department of Healthcare Access and Information (HCAI) and HCAI’s Hospital Equity Measures Advisory Committee to include IBT implementation and completion rates as part of the Equity Reports that facilities will have to publish on their websites beginning in Fall 2025. This would require hospitals to publish IBT quality outcomes on their websites and file annually with HCAI as required under the newly created Hospital Equity Measures Reporting Program.^{aa} The task force should also consider and align its efforts to similar national efforts to include equity in quality measures by the Joint Commission to address health disparities generally^{bb} and the more specific final rule recently promulgated by the Centers for Medicare & Medicaid Services that includes three new equity-focused measures for hospitals to report and establishes a “Birthing-Friendly” hospital designation.^{cc}

Additionally, the task force could work with Cal Hospital Compare to incorporate measures of hospital IBT implementation and maternal outcomes by race as part of the hospital rating systems available to the public through the Cal Hospital Compare website.^{dd}

Lastly, the task force could collaborate with the California Medical Board to establish a specific category of complaints related to discrimination. The Medical Board could add this category to the publicly available information on the complaints the Board receives.

aa. <https://hcai.ca.gov/data-and-reports/healthcare-quality/hospital-equity-measures-reporting-program/>.

bb. <https://www.jointcommission.org/standards/prepublication-standards/new-and-revised-requirements-to-reduce-health-care-disparities/>.

cc. <https://www.cms.gov/newsroom/press-releases/new-cms-rule-increases-payments-acute-care-hospitals-and-advances-health-equity-maternal-health>, <https://www.federalregister.gov/documents/2022/08/10/2022-16472/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the>

dd. <https://calhospitalcompare.org/>.

D. Incentivizing and Enforcing IBT Requirements

The lack of meaningful oversight and enforcement mechanisms in the law is a significant hurdle to ensuring compliance with the law. To address this, the task force should explore options for establishing penalties for non-compliant hospitals and providers. There are currently no specific penalties provided for in the California Dignity in Pregnancy and Childbirth Act, though such penalties are of course made available in other critical areas of quality care oversight and could be similarly applied here. The task force should also consider incentive-based approaches to facility and provider compliance. This could include a recommendation for action by the California Department of Health Care Services to make financial incentives available to Medi-Cal health plans that can show widespread IBT completion or that achieve focal equity targets, such as improved birthing outcomes and patient experience for Black women, birthing people, and other historically affected populations. Additionally, legislators could allocate funds to support facilities' development and implementation of responsive, high-quality trainings. As a complement to these, legislators could fund a public health campaign to educate the public about qualities of respectful maternity care and how to file a complaint if they receive disrespectful or biased care. This would reinforce written information about the latter that SB464 requires hospitals to provide to patients upon admission.

E. Designation of State Agency for Implementation and Long-Term Oversight

In the long-term, it will be crucially important to have a state agency that is tasked with executing and building on the task force's recommendations. As the law currently does not designate any means of oversight, the task force should be responsible for recommending a state agency that the legislature could designate as the oversight body to provide **long-term** supervision of the IBT requirements and provide guidance regarding best practices for implementing high-quality IBT moving forward. In fulfilling this role, the state agency should continue to receive community input by establishing or tasking an existing community advisory committee that includes members of affected communities, specifically Black women and birthing people. The state agency should also consider initiatives that foster collaboration between hospitals and other covered facilities to share their experiences with IBT and other equity initiatives to continue to build on best practices. Initiatives that also engage other stakeholders such as patient safety organizations, health equity organizations, and others working towards addressing inequitable maternal health outcomes could also be effective means to gather insights to help ensure that the IBT requirements of SB 464 are effective as possible.

In summary, SB464's IBT requirement represented a historic opportunity to improve the care and outcomes for Black women, birthing people, and other historically minoritized populations. Key stakeholders and our analysis of the law together identify many opportunities to optimize clinician IBT and to enhance its likely impact. We propose a pathway for the state and hospitals to work toward these goals.

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OTHER RESOURCES

A. Healthcare Provider Implicit Bias Training - Proposed State Legislation 2019-2022 (MEND Study)

Find the report [here](#)

B. MEND Study Main Research Findings (*Health Equity* journal)

Find the article [here](#)


C. MEND IBT Recommendations Checklist & Guide for Hospital-based Teams

Find the facility planning guide [here](#)

D. California Department of Justice (DOJ) Report on Healthcare Facilities and the California Dignity in Pregnancy and Childbirth Act

Find the report [here](#)

If you have questions or wish to discuss this report, you may contact MEND@ucsf.edu or Sarah Garrett, PhD, sarah.garrett@ucsf.edu



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Expanded overview of SB464's provisions to improve data reporting on maternal mortality

Updating the Death Certificate System

SB 464 contains two provisions aimed at improving data reporting on maternal mortality in California. The first provides a statutory update requiring the California Electronic Death Recording System (CA-EDRS) to mirror the U.S. Standard Certificate of Death. These changes to CA-EDRS capture more detailed information about when a patient was pregnant in relation to the time of death. California previously only recorded whether a woman was pregnant in the year before death but did not distinguish when within that year. The new data elements include whether a woman was not pregnant in the last year, pregnant at the time of death, pregnant within 42 days of death or 43 days to one year of death, or whether that information is unknown. Initially, the language in the bill mirrored the language in the U.S. Standard Certificate, however, the Senate amended the bill to read more broadly, “[t]he electronic death registration system shall capture additional information regarding the pregnancy status of the decedent consistent with the data elements on the U.S. Standard Certificate of Death.” This change means that the California death certificate will track all changes made to the U.S. Standard Certificate of Death.

It should also be noted that before the passage of SB 464, this change to CA-EDRS was already underway. In 2015, a workgroup tasked with comparing California's death certificate with the U.S. Standard Certificate of Death concluded that the California death certificate should capture pregnancy status consistent with the U.S. Standard Certificate. Additionally, a collaborative effort between CDPH's Division of Maternal, Child, and Adolescent Health (MCAH), Stanford University's California Maternal Quality of Care Collaborative (CMQCC), and the Public Health Institute, which has been gathering, interpreting, and publishing information on maternal mortality and morbidity since 2006, also called for such a change to provide more detailed data to provide more accurate maternal mortality rate calculations. The California Department of Health (CDPH) was already in the process of modifying CA-EDRS to electronically capture the new data points before the passage of SB 464; the provision in SB 464 codifies the change.

Maternal Mortality and Morbidity Tracking and Reporting by CDPH

The second provision in SB 464 aimed at improving data reporting on maternal mortality in California requires that CDPH track and publish data on maternal morbidity and mortality. With the passage of SB 464, CDPH is statutorily responsible for tracking data on severe maternal morbidity, including conditions such as obstetric hemorrhage, hypertension, preeclampsia and eclampsia, venous thromboembolism, as well as other obstetric complications. The new law then requires CDPH to publish the data they have accumulated every three years. When publishing the data, the law requires CDPH to aggregate the data by state regions but also empowers CDPH to determine if smaller regions would be more appropriate to best reflect how regionalized care systems are or should be collaborating to improve maternal health outcomes, as long as the regions do not risk confidentiality or other disclosure breaches. SB 464 also requires CDPH to disaggregate the data by race and ethnicity.

This section of the bill underwent multiple amendments before the final version that leaves some discretion to CDPH regarding the aggregation and disaggregation of the data. The introduced version of the bill required CDPH to publish the data disaggregated by county, facility, and racial and ethnic identity. Before reaching the final version of the bill, an amendment to resolve patient privacy concerns voiced by the California Hospital Association (CHA) was introduced, which would have required CDPH to aggregate the data by state regions of 100,000 to 200,000 in population, and for the data to be risk-adjusted. The final version of the bill instead gives CDPH discretion as to the aggregation and disaggregation of the data as long as the data does not risk a confidentiality or other disclosure breach.

Prior to SB 464 becoming law and instituting these data gathering and publication requirements, the collaborative mentioned above between MCAH, CMQCC, and the Public Health Institute had been gathering and reporting maternal morbidity and mortality data in California. The collaborative conducts maternal mortality surveillance through vital statistics through the California Pregnancy Mortality Surveillance System (CA-PMSS)^{ee} and conducts in-depth case reviews through the California Pregnancy-Associated Mortality Review (CA-PAMR)^{ff} to gain increased insight into possible contributing factors and opportunities for prevention.^{gg} Funding for both CA-PMSS and CA-PAMR is provided through a federal Title V Maternal and Child Health (MCH) Block Grant.^{hh} The purpose of these block grants is to create federal/state partnerships for developing service systems that address maternal and child health challenges.ⁱⁱ Although the collaborative gathers and publishes data similar to that required by SB 464, it is not mandated to do so by California law. SB 464 presumably fills that gap and provides specific parameters for the type of information CDPH must collect and how CDPH will disaggregate that information before publication. It also requires that the data be published every three years.

ee. In CA-PMSS, cases are identified by linking vital records (i.e., death, birth, and fetal death records) as well as administrative data (i.e., patient discharge, emergency department, and ambulatory surgery center data). This data is then supplemented with coroner and autopsy reports and medical records to confirm pregnancy status, verify timing to death and augment case information. An expert review committee performs a limited case review and determines the cause and relationship to pregnancy for each death. The collaborative states that this system creates accurate maternal mortality information that is crucial data on pregnancy-related trends in California. CA-PMSS 2021, *supra* note 10, at 6.

ff. The CA-PAMR looks at the causes of these deaths, factors that contributed to them, and improvement opportunities in maternal care and support, with an ultimate goal to reduce preventable deaths and associated health disparities. CA-PMSS 2021, *supra* note 10, at 6.

gg. CA-PMSS 2021, *supra* note 10, at 6.

hh. <https://www.cdph.ca.gov/Programs/CFH/DMCAH/CDPH%20Document%20Library/PAMR/CA-PAMR-Report-1.pdf>. Title V block grants are administered by the Maternal and Child Health Bureau (MCBH) within the Department of Human and Health Services (HHS).

ii. <https://mchb.tvisdata.hrsa.gov/uploadedfiles/TvisWebReports/Documents/blockgrantguidanceappendix.pdf>. P. 1