CALIFORNIA

DEPARTMENT OF JUSTICE

REPORT ON HEALTHCARE FACILITIES AND THE CALIFORNIA DIGNITY IN PREGNANCY AND CHILDBIRTH ACT

OCTOBER 2023

Foreword: Understanding Implicit Bias in Black Maternal and Infant Health

In recent years, the discourse surrounding maternal and infant health has evolved to encompass a vital yet often overlooked aspect: the role of implicit bias. This report marks a significant step forward in shedding light on the profound impact of implicit bias on maternal and infant health outcomes. It is with a deep sense of responsibility and dedication that we present this comprehensive analysis, revealing the complex interplay between healthcare disparities, implicit bias, and the urgent need for transformative change.

Implicit bias, often rooted in systemic racism, has insidiously infiltrated healthcare settings. The consequences of this bias are far-reaching, leading to unequal access to quality care and, tragically, adverse health outcomes. This was seen this year with the untimely and preventable deaths of April Valentine and Bridgette Cromer. As we confront this issue head-on, it is crucial to recognize that implicit bias is a reflection of broader societal constructs that have affected the quality of healthcare that Black women receive in the US.

The journey toward equitable maternal and infant healthcare is one marked by both progress and persistent challenges. Our society has made significant advancements in medical knowledge, technology, and healthcare practices. Nevertheless, the stark disparities in maternal and infant outcomes—particularly within Black communities—demand our unwavering attention and proactive measures to address their underlying causes.

This report is more than a compilation of data; it is a call to action. Through meticulously gathered statistics and insightful analysis, we aim to foster a deeper understanding of the intricate web of factors that contribute to Black maternal and infant health disparities. By confronting implicit bias, we endeavor to pave the way for transformative shifts in healthcare policies, practices, and societal attitudes.

We are thankful to Attorney General Rob Bonta and his office for their contributions to this report. Their commitment to dismantling systemic biases and championing equity in maternal and infant health is commendable. Together, we forge a path toward a future in which every Black mother and infant receives the respect, dignity, and care they deserve.

It is our hope that this report serves as a catalyst for informed conversations, strategic collaborations, and resolute actions that will lead us to a future where Black maternal and infant health disparities are eradicated and all families experience safe and nurturing beginnings.

With a shared commitment to reproductive justice and equity,

Janette Robinson-Flint
Black Women for Wellness
Executive Director

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I. EXECUTIVE SUMMARY

This report presents data and findings regarding initial compliance by healthcare facilities with the requirements of the California Dignity in Pregnancy and Childbirth Act (Sen. Bill No. 464 (Mitchell) (2019-2020 Reg. Sess.)), Health & Safety Code, section 123630 et seq. (the "Act"), which took effect on January 1, 2020. The Act requires implicit bias training for perinatal care providers at covered hospitals, primary care clinics, and alternative birth centers (collectively referred to as "covered facilities" or "facilities"). Specifically, the statute requires that covered facilities "implement an evidence-based implicit bias program for all health care providers involved in the perinatal care of patients within those facilities." (Health & Saf. Code, § 123630.3, subd. (a).)

The Department of Justice (DOJ) used informal letter requests and an electronic survey to collect compliance data from 242 California facilities for the period between January 1, 2020, the effective date of the statute, and July 8, 2022.[1] This report provides both the data and DOJ's findings drawn from the data.

Of the 258 facilities to which DOJ issued a letter or a survey, 242 (93.79%) responded with data. On average, 81.44% of the relevant staff in those facilities had completed the required training by July 8, 2022. While this number may appear high, a substantial number of facilities had not completed or even begun training staff until after receiving DOJ's August 23, 2021 letter, despite the January 1, 2020 effective date of the training requirement.[2]

II. KEY FINDINGS

1. Training Rates:

Despite the fact that the law took effect on January 1, 2020, 42 hospitals had not fully trained any employees prior to being contacted by the DOJ on August 23, 2021.

By July 8, 2022, of the 242 facilities:

- Forty-two facilities (17.35%) had completed training *all* staff.
- One-hundred and eighty-five facilities (76.44%) had trained some but not all covered providers by DOJ's reporting deadline. Among these, an average of 77.54% of appropriate providers had been trained.
- Two facilities (00.82%) reported that none of their staff had finished training.
- Thirteen facilities (00.05%) failed to provide information, and therefore the percentage of providers who completed the training at those facilities could not be calculated.

2. Training Approaches:

The vast majority of hospitals used an asynchronous training, *i.e.,* a one- to two-hour training provided via video, developed by Diversity Science, called "Dignity in Pregnancy and Childbirth."

1 DOJ focused on hospitals because more than 98% of births in the United States occur in hospitals. Reese, *Home Births Gain Popularity in 'Baby Bust' Decade* (September 22, 2021) Kaiser Health News, https://khn.org/news/article/home-births-gain-popularity-in-baby-bust-decade/.

2 While the Act does not explicitly state the date by which initial trainings must be completed, it has an effective date of January 1, 2020.

III. BACKGROUND

Discrimination is multidimensional. Structural racial inequities that are determinants of health outcomes include housing, employment, education, and income disparities. These structural inequities underlie implicit or unconscious biases against patients from protected populations, including Black birthing mothers.[3] Unconscious racism, or implicit bias, is thus also a determinant of health disparities. According to field experts, "discrimination due to implicit bias must be addressed because it unnecessarily decreases the quality and length of life of people in this country who are not white."[4] Unfortunately, implicit bias is a key determinant of health that current civil rights and other legal frameworks are ill-equipped to address effectively.[5] The California Dignity in Pregnancy and Childbirth Act represents an important step forward in the creation of an effective legal framework to account for unconscious racism and other forms of bias.[6]

A. Maternal Mortality and Implicit Bias

The United States has the highest maternal mortality rate among high income countries.[7] In California, the rate of maternal death since 2006 has decreased by 55% even though the rate in the United States as a whole has steadily increased.[8] However, for women of color, and in particular Black women, the rate remains three to four times higher than that for white women in California.[9] The racial disparity is even starker when looking at particular conditions.[10] Black women account for 5% of those pregnant in California but account for 21% of the total pregnancy-related deaths.[11] Further, the disparity in maternal health between Black and non-Hispanic white birthing mothers exists independent of the socio-economic status of the birthing mother. A recent study that looked at the records of millions of births in California illustrates that across all parental income levels, Black mothers, as well as their infants, have much worse health outcomes than their non-Hispanic white counterparts do.[12]

The recent COVID-19 pandemic has only exacerbated this tragic disparity. Nationwide, the number of maternal deaths around March 2020, the start of the pandemic, increased by a third, though the

3 Matthew, *Just Medicine: A Cure for Racial Inequality in American Health Care* (2015) pp. 229-230.

4 *Ibid.*; *see also* Lacy, et al., *Black Maternal Health Crisis Requires Support for Black HealthCare Workers* (July 23, 2023), https://www.chcf.org/blog/black-maternal-health-crisis-requires-support-black-health-care-workers/ ("Burnout and attrition among Black health care professionals adds urgency to the Black maternal health crisis, given that research has documented better health outcomes among patients who receive racially concordant care (where the provider and patient share the same racial identity)").

5 *Id.* at pp. 229-230.

6 Valerio, et al., *Black-White disparities in maternal vulnerability and adverse pregnancy outcomes: an ecological population study in the United States, 2014-2018* (2023) https://doi.org/10.1016/j.lana.2023.100456 (finding that locally-informed precision health interventions and further research into racism are needed to achieve maternal health equity).

7 Health & Saf. Code, § 123630.1, subd. (b); *see also* MacDorman, et al, *Racial and Ethnic Disparities in Maternal Mortality in the United States Using Enhanced Vital Records, 2016-2017* (August 2021) 111 Am. J. Public Health 1676 https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2021.306375 (evaluating U.S. maternal mortality rate).

8 *Ibid.*; California Maternal Quality Care Collaborative, *CA-PAMR (Maternal Mortality Review)* https://www.cmqcc.org/research/ca-pamr-maternal-mortality-review; Public Health Institute, *California Pregnancy-Associated Mortality Review: California Pregnancy-Related Deaths*, (June 28, 2022) https://www.phi.org/thought-leadership/california-pregnancy-associated-mortality-review-california-pregnancy-related-deaths-2008-2016/.

9 Health & Saf. Code, § 123630.1, subd. (c); California Department of Public Health, Maternal, Child and Adolescent Health Division, *The California Pregnancy-Associated Mortality Review. Report from 2002-2007 Maternal Death Reviews*, https://www.cmqcc.org/sites/default/files/CA-PAMR-Report-1%20%283%29.pdf>; Petersen, et al., *Vital signs: pregnancy-related deaths, United States, 2011–2015, and strategies for prevention, 13 states, 2013– 2017* (May 10, 2019) 68 (18) CDC MMWR 423. The DOJ recognizes that not all individuals with uteruses identify as "women" in the common use of that term to refer to gender identity.

10 For example, postpartum cardiomyopathy is the leading cause of later maternal deaths but black women die from it six times more often than white women. MacDorman, *supra,* 111 Am. J. Public Health at p. 1676.

11 Health & Saf. Code, § 123630.1, subd. (c); California Department of Public Health, Maternal, Child and Adolescent Health Division, *The California Pregnancy-Associated Mortality Review* (Spring 2018), at p. 25.

12 Kennedy-Moulton, et al., *Maternal and Infant Health Inequality: New Evidence from Linked Administrative Data* (November 2022) National Bureau of Economic Research, Working Paper 30693, DOI 10.3386/w30693.

majority of the increase was among Black and Hispanic birthing mothers.[13] Seventy four percent of the increase is attributable to a rise in deaths among Hispanic birthing mothers and 40% among Black birthing mothers, whereas the rate increase for white birthing mothers was 17.2%.[14] With the Supreme Court's recent ruling in *Dobbs v. Jackson Women's Health Organization* already resulting in reduced access to abortion in many states, these rates could increase, and the impact is expected to fall disproportionately on Black women and other people of color.[15]

A body of evidence illustrates that implicit bias in the healthcare system appears to be one key cause of the racial disparity in maternal mortality statistics.[16] Implicit bias can automatically activate and influence human behavior without a person consciously understanding that bias is leading to their behavior.[17] Preliminary evidence illustrates a strong correlation between a provider's level of bias and the quality of care they provide.[18] Evidence shows that implicit bias significantly affects interactions between patients and providers, provider treatment decisions, adherence to treatments, and actual health outcomes.[19] Studies have shown an association between implicit racial bias and diagnostic uncertainty and, for Black patients, negative ratings of their clinical interactions, less patient centeredness, poor provider communication, under treatment of pain, and providers' views of Black patients as less compliant with treatment recommendations than white patients.[20] In some testing, implicit attitudes were found to be significantly related to patient-provider interactions and health outcomes more often than treatment processes.[21]

Such evidence and literature are consistent with the reports of Black mothers and other pregnant Black people. In California, nearly one-third of Black patients surveyed reported that they did not feel that delivery room staff encouraged them to make decisions about their birth progression, and more than 10% reported that they were treated unfairly during their hospital stay because of their race or ethnicity.[22] Black patients in California also reported feeling pressured to have a cesarean birth almost twice as often as white patients, and 42% ended up giving birth by cesarean section, a procedure associated with excess risk and cost, compared to only 29% of white patients.[23] Studies show that racial bias is likely one key cause of the reported disparity.[24]

Evidence suggests that implicit bias can hinder providers' ability to accurately assess patients' views on treatment, curtail productive discussion, and undermine trust and engagement in care, leading to less follow-up and worse adherence to treatment plans.[25] Changing the way that healthcare providers

13 Thoma, et al., *All-Cause Maternal Mortality in the US Before vs During the COVID-19 Pandemic* (June 28, 2022) 5(6) JAMA Netw Open e2219133.
14 *Ibid.*
15 Bose, *Roe v Wade Ruling Disproportionately Hurts Black Women, Experts Say* (June 27, 2022) Reuters https://www.reuters.com/world/us/roe-v-wade-ruling-disproportionately-hurts-black-women-experts-say-2022-06-27.
16 "Implicit bias" is a bias in judgment or behavior that results from subtle cognitive processes, including implicit prejudice and implicit stereotypes that often operate at a level below conscious awareness and without intentional control. (Health & Saf. Code, § 123630.2, subd. (b).); Hall, et al., *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review* (December 2015) 105(12) Am. J. Public Health e60-e76; Howell, *Reducing Disparities in Severe Maternal Morbidity and Mortality* (June 2018) 61(2) Clin Obstet Gynecol. 387–399.
17 Hall, et al., *supra*, 105(12) Am. J. Public Health e60–e76.
18 Fitzgerald and Hurst, *Implicit bias in healthcare professionals: a systematic review* (March 2017) 1 BMC Med Ethics. 18(1):19; Hagiwara, et. al., *A Call for Grounding Implicit Bias Training in Clinical and Translational Frameworks* (May 2020) 395(10234) Lancet 1457-1460.
19 *Ibid.*
20 Sabin, *Tackling Implicit Bias in Health Care* (July 14, 2022) 387;2 N. Engl. J. Med. 105.
21 Hall, et al., *supra*, 105(12) Am. J. Public Health e60-e76.
22 Glover and Godbolt, *Listening to Black Mothers in California*, at pp. 2-3 (Sept. 2018) National Partnership for Women & Families, https://www.nationalpartnership.org/our-work/resources/health-care/maternity/listening-to-black-mothers-in-california.pdf.
23 *Id*. at p. 4.
24 *Id*. at p. 7.
25 Zestcott, Blair and Stone, *supra*, 19 Group Process Intergroup Relat 528-42; Hall, et al., *supra*, 105(12) Am. J. Public Health e60-e76.

recognize and overcome their own implicit bias when treating pregnancy is a critical step in addressing the racial disparity in maternal morbidity rates.[26]

While studies examining the effectiveness of anti-implicit bias training among medical providers in the field continue to develop, there are a number of completed studies finding that such training, if grounded in a comprehensive, evidence-based approach, can succeed in significantly reducing implicit stereotyping and prejudice in participants.[27] Such evidence supports the conclusion that comprehensive, multifaceted implicit bias training can help individuals become more attuned to their own biases and lead to improved patient outcomes.[28]

B. The California Dignity in Pregnancy and Childbirth Act (SB 464)

To address the racial disparity in maternal mortality, on October 7, 2019, the Governor signed Senate Bill 464 (Mitchell), the California Dignity in Pregnancy and Childbirth Act (the "Act").[29] The Act, which received widespread support from stakeholders and legislators, requires, in relevant part, that as of January 1, 2020, hospitals, alternative birth centers, and primary care clinics conduct evidence-based implicit bias training for all "health care providers involved in the perinatal care of patients within those facilities."[30] It also requires that such providers complete refresher training every two years after the initial training.[31] Hospitals must also provide implicit bias training to new nursing graduates they hire.[32]

C. DOJ's Investigation

To ascertain compliance with the Act's training requirements, DOJ sent a letter on August 23, 2021, to covered facilities.[33] Through this letter, DOJ requested that each facility provide:

- Dates of any implicit bias training providers have completed;
- Dates of implicit bias trainings planned for the future;
- Lists of attendees at each training;
- Copies of all written training materials used;
- A list of the perinatal healthcare workers at each facility who have yet to participate in any training; and
- A description of each facility's efforts to reduce implicit bias among its perinatal healthcare providers.

DOJ further requested that facilities provide responsive documents and information by September 20, 2021. One hundred and fifty facilities requested, and were granted, an extension and did not produce any responsive documents or information until early January 2022. DOJ continued to receive information from a small minority of letter recipients through April 2022. Many facilities and hospital systems responded but failed to provide all of the information that DOJ requested.

26 Howell, *supra*, 61(2) Clin Obstet Gynecol. 387-399. Matthew, *supra,* 33-54.
27 Zestcott, Blair and Stone, *supra*, 19 Group Process Intergroup Relat 528-42; Devine, et al., *Long-term reduction in implicit race bias: a prejudice habit-breaking intervention* (2012) 48 J. Exp Soc Psychol 1267-78; Stone, et al., *Testing active learning workshops for reducing implicit stereotyping of Hispanics by majority and minority group medical students* (2019) 5 Stigma Health 94-103; Howell, *supra*, 61(2) Clin Obstet Gynecol. 387–399.
28 Devine, et al., *supra*, 48 J. Exp Soc Psychol at pp. 1267-78; Howell, *supra*, 61(2) Clin Obstet Gynecol. 387-399; Hagiwara, et. al., *supra*, 395(10234) Lancet 1457-1460.
29 While serving in the California Senate, Holly Mitchell authored the bill.
30 Health & Saf. Code, § 123630.3.
31 *Ibid.*
32 Health & Saf. Code, § 123630.5.
33 Initially, the Department sent the letter to 228 facilities. The Department subsequently identified eight additional covered facilities and sent letters to those facilities in March of 2022.

DOJ sent the letter recipients an electronic survey on June 20, 2022, to allow each facility another opportunity to provide the information requested by July 1, 2022. DOJ also identified additional covered facilities and sent surveys to those facilities. DOJ provided two extensions for responses to the survey, extending the deadline for all letter recipients to July 8, 2022. For any recipient that experienced technical difficulties with the survey, DOJ also offered the option of filling out and returning a PDF version of the survey.

In total, DOJ queried 258 hospitals. By the deadline, DOJ received substantive data from 242 hospitals.

Not all hospitals responded to each query with responsive data. Six facilities never responded to DOJ's requests for information.[34] Four facilities responded but never provided data.[35] And six facilities indicated that they were no longer in operation or providing perinatal care.

DOJ has assembled the information that the covered facilities reported and presents the compliance data in this report.

IV. UNDERSTANDING THE DATA

Appendix A contains the data DOJ collected. The below analysis highlights a few findings that are relevant to the conclusions drawn in the Findings section below.

The data provided and analyzed in this report is for the 242 facilities that reported data but some of the analysis is based on subsets of the 242 responses, as not all facilities responded to each question in a way that presented identifiable data.

Training Rates

Forty-two out of the 242 facilities had completed training all staff by July 8, 2022. One hundred and eighty-five of the responding hospitals had trained some but not all covered providers by the DOJ's reporting deadline. Two facilities reported that none of their staff had finished a training. The percentage of providers who completed the training could not be calculated for 13 hospitals because they failed to provide information.

On average, 81.44% of the staff in responding facilities completed the required training. In other words, the average "completion rate" across all 242 responding hospitals was 81.44 percent.

The 185 hospitals that were not in total compliance trained an average of 77.54% of the appropriate providers in their facilities. Below, Figure 1 displays a histogram of the completion results for all hospitals. Of the 117 hospitals in the 90-100% range, 42 were at 100%.

34 Catalina Island Medical Center, Greater El Monte Community Hospital, Kern Valley Healthcare District, Mayers Memorial Hospital, Memorial Hospital of Gardena, and PIH Health Hospital – Downey.

35 Banner Lassen Medical Center, Mark Twain Medical Center, St. Francis Memorial Hospital, and St. Mary Medical Center.

Figure 1: Completion Rate at All Hospitals

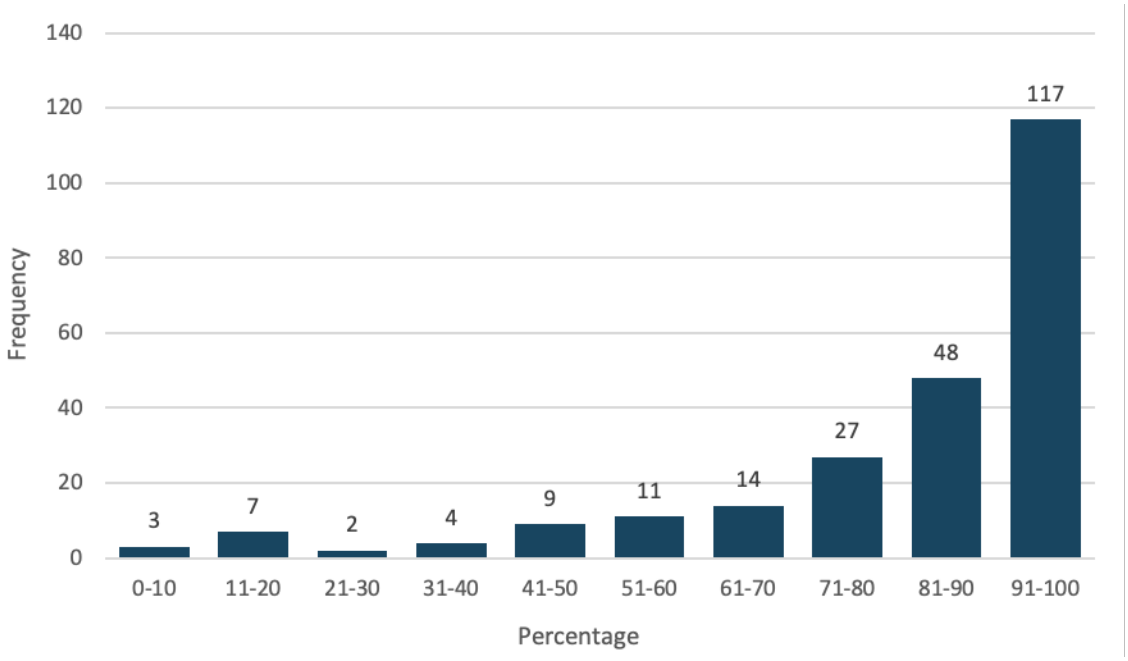


Table 1. Average Completion Rate by Hospitals

Hospitals Considered	Mean %
All Hospitals	81.44
Hospitals that have not completed training	77.54

By position

One hundred and ninety-five facilities reported their figures in a way that allowed analysis of completion rates by at least one position. The data showed that doctors' training completion rates lagged behind those of other providers.

Table 2. Average Completion Rate by Position by Hospital

Position	% Complete	Included
Doctors	71.98	169
Nurses	87.01	188
Other	79.37	168

By facility type

DOJ further disaggregated the rates of training completion by facility type. Specifically, the analysis identified whether each hospital is owned or managed by a private corporation, a nonprofit, the government, or part of the University of California.

Private, government, and university hospitals all had similar average completion rates. Nonprofit hospitals, which are the most common in the data, lagged behind other types by between roughly 10 and 15 percentage points across most metrics.

Table 3. Average Completion Rate by Hospital Ownership

Facility Type	Mean %	Absent[36]	Total
Private	80.01	7	41
Nonprofit	80.51	7	171
Government	86.26	2	38
Univ. of California	84.81	0	8
Total	81.44	16	258

Completion rates are generally consistent between positions for government and university hospitals, while there is substantial variation for private and nonprofit institutions. For example, nurses at private and nonprofit institutions are significantly more likely to have completed training than doctors at those same institutions. Because fewer hospitals reported their data by position, the hospitals that did report by position form a unique subset, but among these hospitals that did report their data by position, universities reported higher overall training completion rates.

Table 4. Completion Rate by Position and Ownership

Facility Type	Doctor %	Nurse %	Other %	Total
Private	66.45	84.23	67.08	16
Nonprofit	69.08	87.29	79.01	122
Government	82.58	85.26	84.17	26
University	99.46	100	100	4

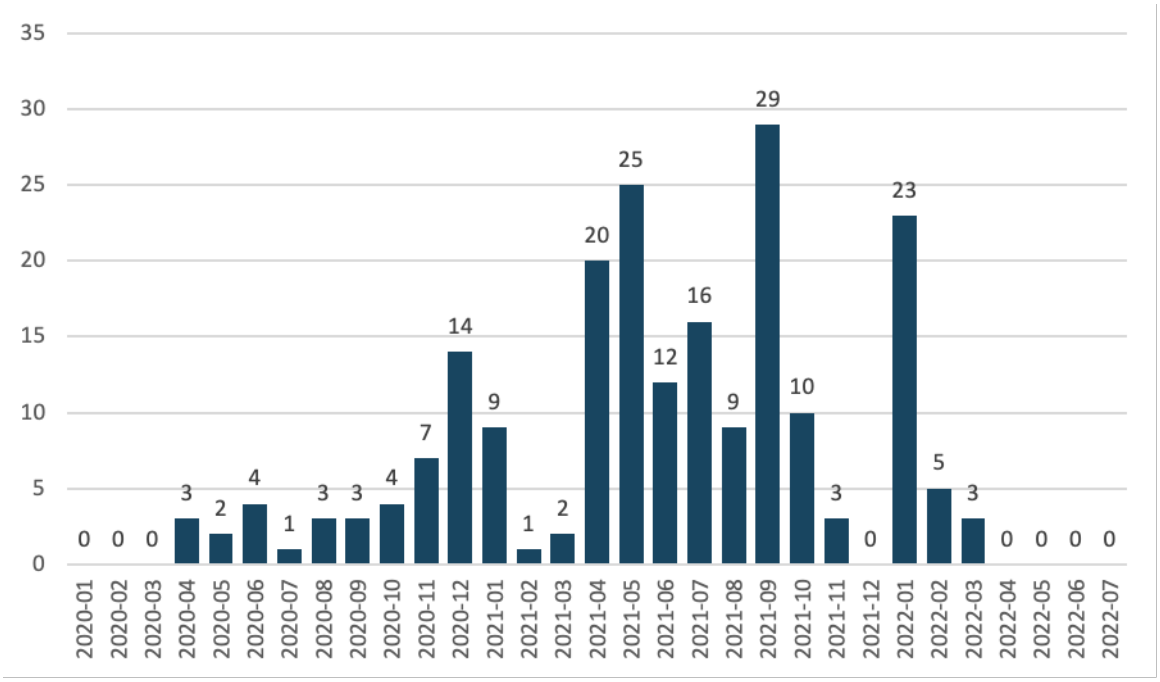
Completion Dates

Facilities started and completed the mandatory anti-bias trainings at different times. Some took action in response to SB 464 shortly after it took effect on January 1, 2020. Specifically, 41 facilities began training providers in 2020. Conversely, 42 facilities did not fully train a single employee prior to the Attorney General's letter, dated August 23, 2021. That is in addition to the two hospitals that have not yet begun training any providers.

Figure 2 below displays the count of hospitals that started the training in each month. In a typical month, 2-3 hospitals' staff complete the training, with spikes occurring intermittently. Training began slowly across hospitals, as the law took effect at the beginning of 2020 and less than half of hospitals began training in the first year. September 2021, the month after DOJ began contacting hospitals about compliance, was the most common month for training to begin. Seventy-three hospitals, nearly a third of the hospitals from which responses were received, began training after that point.

36 Absent counts hospitals without data for any reason.

Figure 2: Hospitals Starting Training by Month



Training Approaches

The vast majority of hospitals (166 out of those reporting) used an asynchronous training, *i.e.,* a one-to two-hour training that is not live instruction but provided via video, developed by Diversity Science, and called "Dignity in Pregnancy and Childbirth." Diversity Science is a public benefit corporation that developed its training with the goal of satisfying the requirements of the Act.[37] Three hospitals reported holding primarily in-person courses as part of their program. All hospitals using synchronous (*i.e.*, live, in-person) training used multiple training approaches, utilizing Diversity Science's courses in addition to lectures and seminars held in person.

Table 5. Training Providers

Training Provider	Count	Mean % Completing
Diversity Science	166	80.75
Multiple	34	79.07
Internal/Self-Created	14	87.85
Unidentified	8	83.08
Culturally and Linguistically Appropriate Services (CLAS)	4	73.85
Flex Ed	3	89.08
ENACT	2	99.04
California Maternal Quality Care Collaborative	1	98.41
Health Stream	1	100.00
Hospital Sponsored Grand Rounds	1	100.00
Kimball and Associates	1	84.38

37 Diversity Science, https://www.diversityscience.org/about.

Training Provider	Count	Mean % Completing
March of Dimes	1	42.76
Prime Healthcare Enterprises	1	100.00
Providence Health Stream Modules	1	71.88

Some hospitals provided training that exceeded the requirements of SB 464. In particular, certain hospitals offered additional lectures or seminars on topics related to implicit bias. Some also provided implicit bias training to staff members who were not directly required to take training as part of SB 464. Additionally, some covered hospitals developed new ways of collecting data, created new internal offices or initiatives, and developed new external collaborations in response to the law. For instance, one health system is establishing a data integration effort pulling from multiple sources to promote "a more holistic view of the health and wellbeing of individuals, priority populations, and the communities" they serve. In addition, several hospitals participated in the Cherished Futures for Black Moms & Babies Collaborative (2020). The number of hospitals undertaking each activity can be found in Table 6.

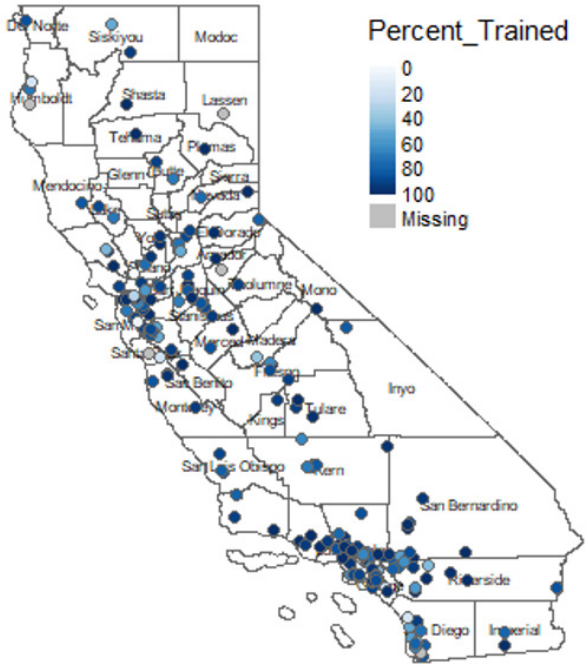
Table 6. Additional Activities Undertaken

Activity	Count
Additional Seminars/Lectures	17
Training Additional Staff	40
New Offices or Initiatives	4
Data Integration	2
External Collaborations	9

Geographic Distinctions

The rate of completion can be observed geographically across California in multiple ways. Figure 3 displays the overall completion rate for each hospital, graphed as an individual point over a map of counties.

Figure 3. Completion Rates Across Hospitals



The role of geography in completion rates for individual hospitals was further investigated by analyzing its correlation to community demographics. Hospitals often serve a broad geographic area, with populations that may stretch across entire counties, making counties a reasonable unit of analysis. Given SB 464's goal of reducing maternal mortality rates for diverse populations, it is worth considering whether community demographics like race and class correlate with completion rates at the hospitals in the area.

Table 7 below displays the correlation between completion percentage at the covered care facility and individual measures of community demographics in the surrounding county. Correlation coefficients range from -1 (perfect negative correlation) to 1 (perfect positive correlation). Coefficients above .8/-.8 are considered to represent "strong" to "very strong" correlations, while coefficients below .4/-.4 are considered to represent "weak" correlations. As displayed in the table, county demographics appear to make little difference in whether hospitals have complied with the requirements of SB 464. However, counties may, in some cases, only serve a subsection of their counties, or may serve a larger radius of the surrounding area. As such, these results should only be taken as preliminary.

Table 7. Correlations with Completion Percentage at County Level

Variable	Correlation
Percentage White	-0.031
Percentage Black	-0.009
Percentage Latino/Latina	0.156
Percentage Asian	-0.169
Percentage Other Race/Ethnicity	0.015
Percentage College Graduate	-0.217
Median Income	-0.162
Total Population	-0.045

V. DATA LIMITATIONS

Facilities submitted data that was compiled into this report in several waves over several months, including a wave in early 2022 and a subsequent survey in July 2022. As such, the report is comparing facilities that responded at different times, and more recent results tend to contain a higher completion rate. While all hospitals had the opportunity to update their figures in the July 2022 survey, it is a limitation that the report is forced to compare organizations at different points in time. In addition, given the different ways that data and information were provided by hospitals, some interpretation of the figures was required in drafting this report.

VI. FINDINGS

Completion Rates

The Legislature enacted SB 464 in 2019, and it took effect on January 1, 2020. DOJ's investigation found that 42 hospitals had not fully trained a single employee prior to being contacted by DOJ on August 23, 2021. Responding hospitals on average completed trainings for 81.36% of their relevant providers, though this figure includes both facilities that completed trainings for all of the appropriate providers and facilities that failed to complete any trainings. Average completion rates were 79.41% at private hospitals, 81.08% at non-profit hospitals, 86.26% at government hospitals, and 84.81% at University of California hospitals. All staff had completed their training at 41 hospitals, and no staff had completed their training at two hospitals.

Nearly a third of facilities to which DOJ reached out, began training only after DOJ contacted them, suggesting that DOJ's outreach caused compliance in many cases.

These findings suggest that rates of compliance with the Act could be increased by establishing (1) training completion deadlines, (2) clear enforcement mechanisms for one or more state agencies to enforce the law, and (3) consequences for non-compliant hospitals and individuals subject to the requirement. We note that the Act does not empower any state agency to issue implementing regulations and does not provide an administrative enforcement scheme with penalties. Further, the Act does not require hospitals to report the failure to meet the training requirements to accreditation and rating entities or report delinquent individuals to licensing agencies or another enforcing state agency.[38]

Transparency and Public Access to Compliance Data

In the future, compliance could be furthered by ensuring more transparency and public access to compliance data. For example, a hospital's failure to comply with the law could be reported on a publicly available registry to enhance consumer awareness and safety.

38 Such entities might include, for example, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Committee for Quality Assurance (NCQA), the American Medical Accreditation Program (AMAP), the American Accreditation HealthCare Commission/Utilization Review Accreditation Commission (AAHC/URAC), Accreditation Association for Ambulatory HealthCare (AAAHC), the Foundation for Accountability (FACCT); the Agency for Healthcare Research and Quality (AHRQ); and consumer-facing and accessible entities such as The Leapfrog Group.

Scope of Trained Providers

In addition, our review revealed confusion among covered facilities as to who is covered by the training requirements. The Act requires training for "all health care providers involved in the perinatal care of patients within" qualifying health facilities.[39] Regulated entities raised questions about this requirement's scope during our review. Questions included what kinds of medical professionals are covered—e.g., physicians, nurses, technicians, orderlies—and whether front desk, telephone, or other support staff are covered. Everyone who interacts with a patient has the potential to affect the patient's experiences and health outcomes.[40] For example, implicit bias could cause an unsupportive receptionist to discourage someone from scheduling an appointment when they need it. Extending implicit bias training requirements to all staff at qualifying health facilities could maximize the training's impact and efficacy.

Perinatal Care Services within a General Acute Care Hospital

Our review similarly found that some General Acute Care Hospitals (GACH) incorrectly believe that the breadth of the law's training requirement only covers providers in primary care clinics, alternative birthing centers, and traditional inpatient perinatal units or labor and delivery departments. However, the law's training requirements can extend to providers in other hospital units and departments as well. A GACH that provides perinatal care in any basic or supplemental service unit is required to provide implicit bias training to the providers in those units. For example, many (if not the majority) of licensed GACHs provide labor and delivery care on an emergency basis, at minimum. Further, outpatient clinics included on a hospital's license are considered part of the hospital and may also provide perinatal services.

California Maternal Mortality Quality Review Committees

Allowing DOJ to access and review relevant California Maternal Mortality Quality Review Committees' (MMRCs)[41] records regarding maternal and infant deaths in noncompliant hospitals could enable the identification of higher-risk facilities for additional training or other corrective measures. California MMRC information is shielded from "public inspection, discovery, subpoena, or introduction into evidence in any civil, criminal, legislative, administrative, or other proceeding."[42] In some cases, this may serve as an overbroad shield from public view and accountability, particularly in the case of noncompliant hospitals or providers.

Evidence-based Training Standards

Requiring or incentivizing clear, evidence-based standards aligned with current research on implicit bias and health outcomes will help ensure that regulated entities can provide effective training for their staff to achieve the goals of the statute. The Act currently provides standards for the creation of implicit bias training programs but no requirement that covered entities regularly review and update their programs

39 Health & Saf. Code, § 123630.3, subd. (a).

40 *E.g.,* Thigpen, *Black Californians Diagnose Structural Obstacles to Equitable Health Care* (Feb. 11, 2022) California Health Care Foundation https://www.chcf.org/blog/black-californians-diagnose-structural-obstacles-equitable-health-care ("Many Black Californians complain that medical office staff (including nurses and physicians) make them feel unwelcome, unnecessarily subjecting them to wait times exceeding that of non-Black patients. They also say that staff disregard their reports of pain. The vast majority of respondents say they receive this kind of treatment because they are Black.").

41 MMRCs "are multidisciplinary committees that convene at the state or local level to comprehensively review deaths during or within a year of pregnancy" (pregnancy-associated deaths). MMRCs have access to clinical and non-clinical information (e.g., vital records, medical records, social service records) to more fully understand the circumstances surrounding each death, determine whether the death was pregnancy-related, and develop recommendations for action to prevent similar deaths in the future." Center for Disease Control, https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/data-mmrc.html.

42 Health & Saf. Code § 123636, subd. (a).

to reflect current evidence-based data.[43] Data are continually developed regarding more effective communication across identities, corrective measures to decrease implicit bias, power dynamics and organizational decision making, and the effects of the historical and contemporary exclusion and oppression of minority communities.[44]

Inclusive Language

Pregnancy and childbirth are not exclusively female experiences. Nonbinary people and men of transgender experience also carry children and give birth.[45] The statute does not explicitly recognize the experiences of all pregnant Black people.[46] Inclusive language is important in creating a safe and compassionate environment where all people feel a sense of belonging. Inclusive language also influences how people reason, problem-solve, and approach issues. Studies have found that language can have a profoundly positive or negative effect on physical and psychological health outcomes.[47]

The statute acknowledges this reality in legislative findings and by requiring that implicit bias programs include "[i]nformation about communicating more effectively across identities, including racial, ethnic, religious, and gender identities."[48] However, the statute does not acknowledge and clarify that non-binary people and transgender men also give birth and are subject to the additional compounding barriers of transphobia, homophobia, and biphobia. While Black maternal mortality is centered in the statute, ideally training should cover all forms of bias experienced by pregnant patients from at-risk groups.

Training is an Important, Basic First Step

Training is an important, basic first step. As discussed above, facility-specific data on maternal mortality and morbidity outcomes are not publicly available. This makes it difficult to study the full extent to which implicit bias training contributes to improved outcomes and to identify and correct systemic problems. Policymakers should consider options to link training requirements to outcome monitoring by an appropriate state agency. This may include:

- Setting hospital improvement metrics or goals and linking them to training. These could be reported to regulators along with training completion metrics.

- Creating a registry that reports metrics or issues grades for similarly situated hospitals, for cases of similar complexity.

43 *Id.* at subd. (a).
44 Health & Saf. Code, § 123630.3, subd. (b).
45 *E.g.,* Taylor Cruz, *As a Pregnant Black Non-Binary Femme, Finding the Right Doula Changed My Life* (Aug. 8, 2019) Self, https://www.self.com/story/finding-the-right-doula; Aaron, *With a Baby on the Way, This Black LGBTQ Couple Is Expanding the Definition of Family and Gender* (Feb. 24, 2022) The Reckoning, https://www.thereckoningmag.com/the-reckoning-blog/with-a-baby-on-the-way-this-black-lgbtq-couple-is-expanding-the-definition-of-family-and-gender#gs.b9yheo; Morris, *Trans Man Who Gave Birth to Two Children Says He Let People Think Pregnancy Bump Was a Beer Belly* (June 4, 2021) Metro, https://metro.co.uk/2021/06/04/trans-man-reveals-trauma-of-going-through-two-pregnancies-and-births-14713068.
46 "Pregnant people," "birthing people," and "pregnant patients" are gender-neutral alternatives to terms like "pregnant women" that can be used to enhance clarity. *E.g.,* Ennis, *New From AP: Use 'Accurate, Sensitive, Unbiased Language' to Cover Trans People* (July 24, 2022) Forbes, https://www.forbes.com/sites/dawnstaceyennis/2022/07/24/new-from-ap-use-accurate-sensitive-unbiased-language-to-cover-trans-people/?sh=65615d058d7b.
47 *See* Julia Nee and Genevieve Macfarlane Smith et al, *Understanding Inclusive Language: A Framework, Center for Equity, Gender & Leadership*, University of California, Berkeley, Haas School of Business (Sept. 15, 2022), https://haas.berkeley.edu/wp-content/uploads/Understanding-IL-Playbook-3.pdf.
48 Health & Saf. Code, § 123630.3, subd. (b)(6); *id.* § 123630.1, subd. (a) ("Every person should be entitled to dignity and respect during and after pregnancy and childbirth. Patients should receive the best care possible regardless of their race, gender, age, class, sexual orientation, gender identity, disability, language proficiency, nationality, immigration status, gender expression, or religion.").

- Setting consequences, such as corrective action plan implementation, for falling below certain metrics.

- Integrating implicit bias training requirements with hospital accreditation and provider licensing examination and renewal requirements.[49]

VII. CONCLUSION

The California Dignity in Pregnancy and Childbirth Act is an important, yet by no means final, step to address disparities in maternal mortality rates. Challenges persist. The Act requiring implicit bias training for covered facilities includes no explicit enforcement mechanism and does not assign oversight of its requirements to any particular agency, undermining its efficacy. Those who do fulfill the requirement are under no obligation or incentive to evolve their training over the years with updated evidence-based and gender-inclusive standards aligned with current research on implicit bias and health outcomes. Those who do not fulfill the requirement are unlikely to face repercussions because a lack of public access to compliance data makes it challenging for consumers to know whether or not their covered provider has fulfilled its obligation. Additionally, California Maternal Mortality Quality Review Committees' (MMRCs) records pertaining to maternal and infant deaths are shielded from public view and accountability, enabling noncompliant facilities to skirt liability.

Moreover, many in the medical community have expressed confusion regarding the scope of SB 424. The Act's language is not specific in defining what positions it requires training for. Every employee who interacts with a patient has the potential to affect a patient's experiences and health outcomes, and should therefore be subject to the requirement (i.e., receptionists, schedulers, billing agencies, etc.). Additionally, some responding hospitals believe that only primary care clinics, alternative birthing centers, and traditional inpatient perinatal units or labor and delivery departments are covered by the law, when in fact the law covers *all* facilities that provide perinatal care. Despite these challenges, DOJ believes that the training mandated by the California Dignity in Pregnancy and Childbirth Act represents a crucial step in improving infant and maternal health outcomes. Given facilities' eventual high training completion rates, DOJ believes there is a willingness among covered care facilities to address these challenges to holistically address infant and maternal health outcomes when under the scrutiny of a state regulator.

49 This approach may also help shape continued improvement of medical, nursing, and other healthcare education and training curricula around the ways in which medical and scientific racism continue to drive health inequalities.

APPENDIX A. COMPLETE DATA (AS OF JULY 8, 2022)

Name	Percentage of All Trained	Percent of Doctors Trained	Percentage of Nurses Trained	Percentage of Other Positions Trained
NE Sutter Health Support Services	100.0%	NA	NA	100.0%
Novato Community Hospital	100.0%	NA	NA	100.0%
Marshall Medical Center	100.0%	NA	NA	NA
Víctor Valley Global Medical Center	100.0%	NA	NA	NA
East Bay Perinatal Center	100.0%	NA	NA	100.0%
Palo Alto Medical Foundation	100.0%	NA	100.0%	NA
Rancho Springs Medical Center	100.0%	NA	NA	NA
Plumas District Hospital	100.0%	100.0%	100.0%	100.0%
Hi-Desert Medical Center	100.0%	NA	NA	NA
Sutter Amador Hospital	100.0%	NA	100.0%	100.0%
Petaluma Valley Hospital	100.0%	NA	NA	NA
St. Elizabeth Community Hospital	100.0%	NA	100.0%	NA
Adventist Health Mendocino Coast	100.0%	100.0%	100.0%	100.0%
San Dimas Community Hospital	100.0%	100.0%	100.0%	NA
Mammoth Hospital	100.0%	100.0%	100.0%	100.0%
Montclair Hospital Medical Center	100.0%	100.0%	100.0%	NA
Doctors Hospital of Manteca	100.0%	NA	NA	NA
Hazel Hawkins Memorial Hospital	100.0%	100.0%	100.0%	100.0%
Tahoe Forest Hospital	100.0%	100.0%	100.0%	NA
Hemet Global Medical Center	100.0%	NA	NA	NA
Desert Valley Hospital	100.0%	100.0%	100.0%	100.0%
El Centro Regional Medical Center	100.0%	100.0%	100.0%	100.0%
Beverly Hospital	100.0%	100.0%	100.0%	100.0%
JFK Memorial Hospital	100.0%	NA	100.0%	100.0%
SM&SC- Maternity & Surgery	100.0%	NA	100.0%	100.0%
Mercy Hospital Of Folsom	100.0%	NA	100.0%	100.0%
Santa Paula Hospital	100.0%	100.0%	100.0%	100.0%
Ventura County Medical Center	100.0%	100.0%	100.0%	100.0%
Mercy Medical Center – Redding	100.0%	NA	100.0%	100.0%
Washington Hospital Healthcare System	100.0%	100.0%	100.0%	100.0%
Mercy Medical Center – Merced	100.0%	100.0%	NA	NA
Redlands Community Hospital	100.0%	NA	NA	NA
Santa Barbara Cottage Hospital	100.0%	NA	100.0%	100.0%
Doctors Medical Center of Modesto	100.0%	NA	NA	NA
Saint Agnes Medical Center	100.0%	NA	NA	NA
Los Robles Hospital	100.0%	100.0%	100.0%	NA
Bakersfield Memorial Hospital	100.0%	100.0%	100.0%	100.0%
Kaweah Delta Health Care District	100.0%	NA	100.0%	100.0%
UC Davis Medical Center	100.0%	100.0%	100.0%	100.0%
UCSF- San Francisco	100.0%	100.0%	100.0%	100.0%
Loma Linda University Children's Hospital	100.0%	100.0%	100.0%	100.0%

scripps green hospital	100.0%	NA	NA	NA
UCLA Medical Center- Ronald Reagan	99.5%	98.9%	100.0%	100.0%
UCLA Health – Santa Monica	99.4%	98.9%	100.0%	100.0%
St. Joseph's Medical Center- Stockton	99.3%	NA	99.5%	98.4%
Desert Regional Medical Center	98.8%	NA	NA	NA
Valley Presbyterian Hospital	98.8%	100.0%	98.2%	100.0%
Providence Little Company Of Mary- San Pedro	98.6%	94.7%	100.0%	100.0%
Arrowhead Regional Medical Center	98.5%	NA	NA	NA
Martin Luther King Jr. (MLK-La) Community Hospital	98.4%	94.9%	100.0%	100.0%
Stanford Health Care – Valleycare Pleasanton	98.4%	100.0%	98.9%	95.0%
Providence Saint Joseph Medical Center	98.3%	100.0%	99.6%	92.1%
San Ramon Regional Medical Center	98.3%	NA	NA	NA
Sutter Davis Hospital	98.2%	NA	98.1%	100.0%
Highland Hospital	98.1%	97.6%	99.0%	95.2%
UCSF Medical Center at Missing Bay	98.1%	NA	NA	NA
Mission Hospital – Mission Viejo	98.1%	89.5%	98.8%	98.0%
Ridgecrest Regional Hospital	97.9%	100.0%	100.0%	88.9%
Sierra View Medical Center	97.9%	87.5%	100.0%	100.0%
Sutter Medical Plaza Sacramento	97.9%	NA	98.2%	88.9%
San Antonio Regional Hospital	97.8%	100.0%	97.2%	100.0%
Salinas Valley Memorial Hospital	97.6%	100.0%	98.3%	88.9%
Emanate Health Queen Of The Valley Hospital	97.6%	100.0%	97.0%	100.0%
Fountain Valley Regional Hospital	97.3%	NA	NA	NA
Northridge Hospital Medical Center (Dignity Health)	97.1%	97.6%	95.5%	100.0%
Woodland Healthcare	97.0%	NA	96.6%	100.0%
Centinela Hospital Medical Center	96.7%	81.3%	100.0%	100.0%
Adventist Health And Rideout	96.7%	100.0%	97.4%	83.3%
St. Jude Medical Center	96.5%	100.0%	96.4%	96.3%
LAC/Olive View – UCLA Medical Center	96.5%	NA	NA	NA
Providence Little Company Of Mary – Torrance	96.3%	86.1%	99.2%	88.4%
Pih Health – Whittier	96.0%	100.0%	95.3%	NA
Santa Rosa Memorial Hospital	95.8%	NA	NA	NA
Barstow Community Hospital	95.5%	50.0%	100.0%	100.0%
Kaiser Permanente Vacaville Medical Center	95.2%	NA	94.6%	100.0%
Natividad Medical Center	94.6%	NA	NA	NA
Pomona Valley Hospital Medical Center	94.4%	66.7%	98.4%	NA
Adventist Health Simi Valley	94.4%	95.7%	93.3%	100.0%
Kaiser Permanente Moreno Valley Medical Center	94.4%	NA	94.4%	NA
Community Hospital Of San Bernardino	94.2%	NA	93.4%	100.0%
St. John's Regional Medical Center	94.1%	NA	93.9%	100.0%
George L. Mee Memorial Hospital	94.0%	85.4%	97.1%	100.0%
Emanuel Medical Center	94.0%	NA	NA	NA
USC Verdugo Hills Hospital	93.8%	NA	NA	NA
Palomar Medical Center Escondido	93.7%	6.7%	100.0%	100.0%
Saint Louise Regional Hospital	93.5%	NA	93.5%	NA
Contra Costa Regional Medical Center	93.4%	71.1%	100.0%	50.0%
Mercy Hospital Southwest – Bakersfield	93.2%	100.0%	91.6%	90.5%

Mercy Medical Center – Mount Shasta	93.1%	NA	96.2%	66.7%
Adventist Health Hanford	93.1%	100.0%	89.0%	100.0%
Enloe Medical Center	92.9%	90.0%	95.3%	89.2%
LAC/ Harbor – UCLA Medical Center	92.9%	NA	NA	NA
Adventist Health Sonora	92.8%	100.0%	91.7%	NA
St. Rose Hospital	92.7%	100.0%	91.3%	80.0%
St. Mary Medical Center – Long Beach	92.6%	NA	95.6%	88.3%
Lompoc Valley Medical Center	92.6%	100.0%	95.5%	50.0%
Providence Saint John's	92.5%	82.1%	99.4%	97.6%
El Camino Hospital –Mountain View	92.5%	NA	NA	NA
California Hospital Medical Center	92.2%	NA	95.2%	87.9%
Adventist Health Reedly	92.2%	100.0%	89.0%	100.0%
Adventist Health Tulare	92.0%	100.0%	88.9%	100.0%
Orange County Global Medical Center	92.0%	NA	NA	NA
Kaiser Permanente Santa Rosa	92.0%	NA	94.2%	73.7%
Marin General Hospital	91.9%	78.0%	99.0%	100.0%
Miller Children's & Women's Hospital	91.8%	74.3%	94.0%	94.1%
(PIH Health) Good Samaritan Hospital– Los Angeles	91.8%	65.2%	95.9%	95.8%
Sutter Roseville Medical Center	91.6%	NA	91.8%	87.5%
Kaiser Permanente Redwood City Medical Center	91.5%	NA	93.1%	25.0%
Hoag Memorial Hospital	91.4%	76.3%	99.0%	94.3%
Sutter Health California, Pacific Medical Center	91.3%	100.0%	90.9%	100.0%
Sequoia Hospital	90.9%	NA	94.3%	68.8%
Garfield Medical Center	90.7%	79.8%	98.4%	50.0%
Adventist Health Lodi Memorial	90.6%	78.8%	97.5%	100.0%
Twin Cities Community Hospital	90.5%	NA	93.1%	78.7%
Alta Bates Summit Medical Center	90.5%	NA	92.0%	83.9%
Dominican Hospital	90.4%	NA	96.6%	58.8%
Queen Of The Valley M.C. Providence- Napa	90.1%	NA	NA	NA
Kaiser Permanente- Antioch	90.0%	NA	90.5%	80.0%
Huntington Hospital	89.8%	NA	NA	NA
Methodist Hospital Of Sacramento	89.8%	NA	91.2%	85.0%
Mercy San Juan Medical Center	89.8%	NA	92.5%	76.2%
John Muir Medical Center- Walnut Creek	89.5%	64.0%	96.9%	NA
Sutter Lakeside Hospital	89.5%	NA	89.5%	NA
(HHS) O'Connor Hospital	89.2%	NA	92.3%	61.5%
East Los Angeles Doctors Hospital	89.2%	90.0%	92.3%	0.0%
Sutter Auburn Faith Hospital	89.1%	NA	88.6%	100.0%
Kaiser Permanente South Bay Medical Center	89.0%	97.1%	86.5%	NA
Community Regional Medical Center	88.9%	NA	89.5%	88.0%
Sutter Health Memorial Medical Center- Modesto (Sutter Health)	88.3%	NA	87.8%	100.0%
South Coast Global Medical Center	88.0%	25.0%	100.0%	100.0%
Providence Holy Cross	87.6%	66.2%	98.8%	93.0%
St. Bernadine Medical Center (Dignity Health)	87.2%	NA	88.7%	81.8%
Sutter Coast Hospital	86.7%	NA	84.6%	100.0%
Good Samaritan Hospital – San Jose	86.7%	86.7%	NA	NA
Adventist Health White Memorial	86.6%	46.3%	94.3%	NA

Kaiser Permanente Woodland Hills Medical Center	86.5%	84.5%	88.1%	100.0%
Antelope Valley Hospital	86.5%	78.3%	94.0%	84.3%
St. Joseph Hospital- Orange	86.4%	73.9%	93.3%	85.9%
St. Mary Medical Center – Apple Valley	86.3%	47.9%	97.0%	98.1%
Adventist Health Glendale	86.0%	85.5%	86.3%	84.0%
Palo Verde Hospital	85.7%	NA	85.7%	NA
LAC/USC Medical Center	85.5%	NA	NA	NA
Sutter Memorial Hospital Los Banos (Sutter Health)	85.2%	NA	71.4%	100.0%
Hoag Hospital Irvine	85.0%	72.2%	93.9%	92.9%
Sharp Chula Vista Medical Center	85.0%	18.8%	94.0%	NA
Orange Coast Medical Center (Memorial Care)	84.8%	NA	NA	NA
Kaiser Permanente Panorama City Medical Center	84.8%	65.2%	93.9%	NA
Kaiser Permanente Medical Office Modesto	84.6%	NA	84.9%	50.0%
Community Hospital Monterey	84.4%	84.4%	NA	NA
Kern Hospital Medical Center	83.8%	76.3%	85.0%	97.0%
(Sutter's) Eden Medical Center	83.8%	NA	83.8%	NA
Adventist Health Ukiah Valley	83.7%	82.2%	82.7%	100.0%
Clovis Community Medical Center	83.6%	NA	81.0%	87.0%
San Joaquin General Hospital	83.5%	88.9%	83.2%	NA
Kaiser Permanente Santa Clara Medical Center	83.5%	92.9%	85.4%	27.3%
Kaiser Permanente Ontario Vineyard Medical Offices	82.9%	NA	82.9%	NA
Northern Inyo Hospital	82.8%	NA	NA	NA
Sutter Delta Medical Center	82.4%	NA	81.3%	100.0%
Santa Clara Valley Medical Center	82.3%	47.8%	93.2%	88.0%
Sharp Grossmont Hospital	82.0%	NA	NA	NA
UC Irvine Medical Center	81.4%	NA	NA	NA
Sierra Vista Regional Medical Center	81.2%	NA	NA	NA
Adventist Health Bakersfield	81.1%	51.9%	83.9%	86.6%
Parkview Community Hospital Medical Center	80.5%	32.3%	100.0%	77.8%
Providence Cedars-Sinai Tarzana Medical Center	80.4%	38.0%	97.4%	98.5%
Riverside University Medical Center	80.0%	80.0%	0.0%	100.0%
Corona Regional Medical Center	80.0%	52.2%	100.0%	55.6%
Kaiser Permanente Los Angeles	79.5%	59.6%	92.1%	NA
Sharp Mary Birch Hospital	79.4%	16.7%	88.4%	57.9%
Barton Memorial Hospital	79.3%	75.0%	94.7%	33.3%
Marian Regional Medical Center	79.2%	NA	76.6%	84.1%
Kaiser Permanente Riverside Medical Center	78.8%	65.5%	89.3%	NA
Kaiser Permanente- Baldwin Park	78.7%	55.3%	95.9%	33.3%
Kaiser Permanente Roseville Medical Center	78.6%	NA	80.0%	65.7%
Cedars-Sinai Medical Center	78.4%	53.7%	89.3%	78.5%
Pioneers Memorial Healthcare District	78.3%	80.0%	73.9%	66.7%
Henry Mayo Newhall Hospital	77.1%	86.7%	75.3%	NA
Sutter Medical Center Santa Rosa	76.3%	39.6%	86.9%	80.0%
Sierra Nevada Memorial Hospital	76.1%	NA	76.1%	NA
Kaiser Permanente- Downey	76.0%	57.9%	87.4%	NA
North Bay Medical Center	75.4%	100.0%	74.2%	68.0%
Sutter Medical Group	75.3%	76.4%	73.3%	33.3%

Sutter West Bay Medical Group	75.0%	75.0%	NA	75.0%
Palomar Medical Center Poway	74.9%	NA	NA	NA
Mercy General Hospital	73.6%	NA	72.7%	79.2%
St. Joseph Hospital- Eureka	71.9%	0.0%	79.6%	70.0%
Adventist Health Clear Lake	71.4%	27.3%	87.5%	75.0%
Mills Peninsula Health Services	71.2%	NA	70.2%	87.5%
Mills-Peninsula Medical Center	71.2%	NA	41.2%	46.7%
Community Memorial Hospital	70.8%	2.6%	83.6%	77.0%
Zuckerberg San Francisco General Hospital and Trauma Center	70.3%	NA	91.0%	51.7%
Oroville Hospital	70.2%	NA	NA	NA
MERCY SOUTHWEST HOSPITAL	70.0%	35.7%	NA	NA
Sutter Tracy Community Hospital	69.8%	NA	56.4%	91.7%
Palo Alto Medical Group	69.1%	30.0%	100.0%	73.9%
Methodist Hospital of Southern CA	68.5%	NA	NA	NA
Kaiser Permanente San Leandro Medical Center	66.7%	NA	80.0%	0.0%
Glendale Memorial Hospital and Health Center	66.3%	NA	NA	NA
San Gabriel Valley Medical Center	66.0%	81.1%	0.0%	14.3%
Delano Regional Medical Center	65.8%	52.8%	90.0%	28.6%
UC San Diego Medical Center	65.0%	NA	NA	NA
Kaiser Permanente – Fresno Medical Center	64.7%	NA	64.3%	66.7%
Riverside Community Hospital	62.7%	NA	NA	NA
Kaiser Permanente San Francisco Medical Center And Medical Offices	62.6%	100.0%	65.7%	24.3%
AHMC Anaheim Regional Medical Center	62.5%	NA	NA	NA
Torrance Memorial Medical Center	61.0%	54.2%	NA	NA
Whittier Hospital	59.6%	NA	NA	NA
Loma Linda University Medical Center- Murieta	59.0%	100.0%	45.5%	100.0%
Kaiser Permanente Walnut Creek Medical Center	58.2%	NA	65.0%	15.2%
Kaiser Permanente Los Angeles Medical Center	56.7%	36.8%	70.3%	33.3%
Scripps Memorial Hospital La Jolla	55.9%	0.0%	100.0%	NA
Kaiser Permanente – Fontana	55.2%	NA	55.2%	NA
Kaiser Permanente Orange County Irvine Medical Center	54.9%	56.6%	52.1%	NA
REGIONAL MEDICAL CENTER OF SAN JOSE	53.5%	42.1%	61.5%	NA
Scripps Mercy Hospital San Diego	52.9%	0.0%	100.0%	NA
Scripps Memorial Hospital Encinitas	52.5%	0.0%	100.0%	100.0%
Kaiser Permanente South Sacramento Medical Center	51.0%	NA	53.8%	35.0%
Fairchild Medical Center	50.0%	50.0%	NA	NA
Kaiser Permanente San Jose Medical Center	50.0%	NA	56.3%	25.0%
Sutter Gould Medical Group	50.0%	NA	100.0%	48.1%
Kaiser Permanente San Diego Medical Center	48.4%	51.6%	46.1%	0.0%
Sutter Santa Rosa Regional Hospital	46.2%	46.2%	NA	NA
Scripps Mercy Hospital Chula Vista	44.9%	0.0%	100.0%	NA
San Gorgonio Memorial Hospital	44.4%	NA	NA	NA
Kaiser Permanente Orange County Anaheim Medical Center	43.5%	NA	43.5%	NA
El Camino Hospital – Los Gatos	42.8%	25.5%	91.4%	0.0%
Madera Community Hospital	39.4%	NA	NA	NA
Sutter East Bay Medical Group	36.8%	32.4%	43.8%	37.5%
UCSD Health La Jolla	35.0%	NA	NA	NA

Kaiser Permanente Oakland Medical Center	30.8%	0.0%	50.0%	0.0%
french hospital medical center	26.2%	NA	NA	NA
Saddleback Memorial Medical Center	20.5%	78.6%	NA	NA
Watsonville Community Hospital	19.1%	NA	NA	NA
Mad River Community Hospital	17.9%	10.0%	18.2%	28.6%
Tri-City Medical Center Regional	17.7%	NA	17.4%	18.4%
Hollywood Presbyterian Medical Center	13.3%	NA	NA	NA
Adventist Health St. Helena	11.1%	11.1%	NA	NA
Modoc Medical Center	11.1%	20.0%	0.0%	NA
St. Francis Medical Center	10.5%	NA	NA	NA
Lucile Packard- Stanford (Children's Hospital)	4.2%	NA	NA	NA
Sutter North Medical Group	0.0%	NA	NA	0.0%
Kaiser Permanente Vallejo Medical Center	0.0%	NA	0.0%	NA
Anaheim Global Medical Center*	NA	NA	NA	NA
Garden Grove Hospital & Medical Center*	NA	NA	NA	NA
Monterey Park Hospital*	NA	NA	NA	NA
Paradise Valley Hospital*	NA	NA	NA	NA
Redwood Memorial Hospital- Providence*	NA	NA	NA	NA
West Hills Hospital & Medical Center*	NA	NA	NA	NA
Banner Lassen Medical Center^	NA	NA	NA	NA
Mark Twain Medical Center^	NA	NA	NA	NA
St. Francis Memorial Hospital^	NA	NA	NA	NA
St. Mary Medical Center- SF^	NA	NA	NA	NA
Catalina Island Medical Center~	NA	NA	NA	NA
Greater El Monte Community Hospital~	NA	NA	NA	NA
Kern Valley Healthcare District~	NA	NA	NA	NA
Mayers Memorial Hospital~	NA	NA	NA	NA
Memorial Hospital of Gardena~	NA	NA	NA	NA
PIH Health Hospital- Downey~	NA	NA	NA	NA

* = no service

^ = incomplete response

~ = no response