HEALTH AND SAFETY CODE - HSC

DIVISION 106. PERSONAL HEALTH CARE (INCLUDING MATERNAL, CHILD, AND ADOLESCENT) [123100 - 125850] *(Division 106 added by Stats. 1995, Ch. 415, Sec. 8.)*

PART 2. MATERNAL, CHILD, AND ADOLESCENT HEALTH [123225 - 124250] *(Part 2 added by Stats. 1995, Ch. 415, Sec. 8.)*

CHAPTER 2. Maternal Health [123375 - 123643] *(Chapter 2 added by Stats. 1995, Ch. 415, Sec. 8.)*

ARTICLE 4.6. California Dignity in Pregnancy and Childbirth Act [123630 - 123630.7] *(Article 4.6 added by Stats. 2019, Ch. 533, Sec. 3.)*

123630. This article shall be known, and may be cited, as the California Dignity in Pregnancy and Childbirth Act.

(Added by Stats. 2019, Ch. 533, Sec. 3. (SB 464) Effective January 1, 2020.)

123630.1. The Legislature hereby finds and declares all of the following:

(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.

(b) The United States has the highest maternal mortality rate in the developed world. About 700 women die each year from childbirth, and another 50,000 suffer from severe complications. In California, since 2006, the rate of maternal death has decreased 55 percent, in contrast to the steady increase in the United States as a whole.

(c) However, for women of color, particularly Black women, the maternal mortality rate remains three to four times higher than White women. Black women make up 5 percent of the pregnancy cohort in California, but 21 percent of the pregnancy-related deaths.

(d) Forty-one percent of all pregnancy-related deaths had a good to strong chance of preventability. California has a responsibility to decrease the number of preventable pregnancy-related deaths.

(e) Pregnancy-related deaths among Black women are also more likely to be miscoded. Thirty-five percent of pregnancy-related deaths among Black women in California were miscoded, misidentifying pregnancy-related deaths as other deaths.

(f) Access to prenatal care, socioeconomic status, and general physical health do not fully explain the disparity seen in Black women's maternal mortality and morbidity rates. There is a growing body of evidence that Black women are often treated unfairly and unequally in the health care system.

(g) Implicit bias is a key cause that drives health disparities in communities of color. At present, health care providers in California are not required to undergo any implicit bias testing or training. Nor does there exist any system to track the number of incidents where implicit prejudice and implicit stereotypes have led to negative birth and maternal health outcomes.

(h) It is the intent of the Legislature to reduce the effects of implicit bias in pregnancy, childbirth, and postnatal care so that all people are treated with dignity and respect by their health care providers.

(i) The Legislature recognizes all birthing people, including nonbinary persons and persons of transgender experience.

(j) All persons who may interact with perinatal patients to gatekeep, facilitate, or coordinate access to timely, responsive, respectful, and appropriate medical care may impact Black birthing persons' maternal mortality and morbidity outcomes, including, but not limited to, hospital or facility employees who facilitate, control, or directly or indirectly coordinate access to timely and appropriate medical treatment as well as those who provide medical and ancillary treatment.

(Amended by Stats. 2024, Ch. 621, Sec. 1. (AB 2319) Effective January 1, 2025.)

123630.2. For the purposes of this article, the following terms have the following meanings:

(a) “Pregnancy-related death” is the death of a person while pregnant or within 365 days of the end of a pregnancy, irrespective of the duration or site of the pregnancy, from any cause related to, or aggravated by, the pregnancy or its management, but not from accidental or incidental causes.

(b) “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.

(c) “Implicit prejudice” is prejudicial negative feelings or beliefs about a group that a person holds without being aware of them.

(d) “Implicit stereotypes” are the unconscious attributions of particular qualities to a member of a certain social group. Implicit stereotypes are influenced by experience and are based on learned associations between various qualities and social categories, including race or gender.

(e) “Perinatal care” is the provision of care during pregnancy, labor, delivery, and postpartum and neonatal periods. “Perinatal care” includes, but is not limited to, prenatal care.

(Amended by Stats. 2024, Ch. 621, Sec. 2. (AB 2319) Effective January 1, 2025.)

123630.3. (a) A hospital as defined in subdivision (a) or (f) of Section 1250 that provides perinatal care, and an alternative birth center or primary care clinic subject to Section 1204.3, shall implement an evidence-based implicit bias program for all health care providers involved in the perinatal care of patients within those facilities, including:

(1) All persons licensed under Division 2 of the Business and Professions Code (commencing with Section 500) who are regularly assigned to provide perinatal care, including, but not limited to, those in primary care clinics, alternative birthing centers, outpatient clinics, or emergency departments.

(2) All persons who are regularly assigned to positions where they interact with perinatal patients, including, but not limited to, physician assistants, medical assistants, licensed vocational nurses, doctors, or those who facilitate, control, or coordinate access to timely and appropriate medical treatment, as well as any others who provide medical and ancillary treatment.

(b) An implicit bias program implemented pursuant to subdivision (a) shall include all of the following:

(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 decisionmaking.

(8) Discussion on health inequities within the perinatal care field, including information on how implicit bias impacts maternal and infant health outcomes.

(9) Perspectives of diverse, local constituency groups and experts on particular racial, identity, cultural, and provider-community relations issues in the community.

(10) Information on reproductive justice.

(11) Recognition of intersecting identities, including, but not limited to, nonbinary persons and persons of transgender experience, and the multiple layers of potential biases that could come into play, resulting in harm to patients and their infants.

(c) (1) A health care provider described in subdivision (a) shall complete initial basic training through the implicit bias program based on the components described in subdivision (b). This initial basic training must be completed by June 1, 2025, for all current health care providers. The initial basic training must be provided to new health care providers at all facilities within six months of their start at the new facility unless subdivision (d) applies.

(2) Upon completion of the initial basic training, a health care provider shall complete a refresher course under the implicit bias program every two years thereafter, or on a more frequent basis if deemed necessary by the facility, in order to keep current with changing racial, identity, and cultural trends and best practices in decreasing interpersonal and institutional implicit bias.

(3) The training shall be provided during paid work time.

(d) A facility described in subdivision (a) shall provide a certificate of training completion to another facility or a training attendee upon request. A facility may accept a certificate of completion from another facility described in subdivision (a) to satisfy the training requirement described in subdivision (c) for a health care provider who works in more than one facility.

(e) Notwithstanding subdivisions (a) to (d), inclusive, if a physician involved in the perinatal care of patients is not directly employed by a facility, the facility shall offer the training to the physician.

(f) By February 1 of each year, commencing in 2026, a facility described in subdivision (a) shall provide the Attorney General with proof of compliance. Proof of compliance shall include all of the following:

(1) A list of all of the health care providers described in paragraph (1) of subdivision (a) who completed the training requirements outlined in subdivision (c).

(2) The dates that each health care provider completed their training.

(3) The written materials used in the training.

(4) A description of the training, including substance, format, and duration.

(5) A list that outlines the categories by job title of the health care providers described in paragraph (1) of subdivision (a) who did not participate in the training, if any. Each category shall include both of the following:

(A) A delineation of the respective health care provider or providers by employee status.

(B) The number and percentage of the health care providers who failed to complete the training out of the total relevant health care providers within the respective category.

(g) A facility described in subdivision (a) that violates the requirement to implement an implicit bias program pursuant to subdivision (a) of this section, or fails to submit proof of compliance to the Attorney General pursuant to subdivision (f) of this section shall be liable for a civil penalty of five thousand dollars ($5,000) for the first violation and fifteen thousand dollars ($15,000) for the second and each subsequent violation. In the event a facility's proof of compliance submitted to the Attorney General reveals systemic failure of providers to complete the training requirements outlined in subdivision (c), the facility shall be liable for a civil penalty of five thousand dollars ($5,000) for the first violation, and fifteen thousand dollars ($15,000) for the second and each subsequent violation. Civil penalties specified in this subdivision shall be assessed and recovered in a civil action brought in the name of the people of the State of California by the Attorney General in any court of competent jurisdiction. The Attorney General shall be awarded all attorney's fees and costs in any civil action in which a court imposes any of the penalties described in this section. The penalties provided by this subdivision are not exclusive and do not limit other remedies available in law for such violations.

(h) (1) For purposes of subdivision (g), "systemic failure" means the lesser of the following:

(A) Ten percent or more of providers failing to complete the training, provided that if only one or two providers did not receive the training, the facility was provided a reasonable opportunity to cure before a penalty is pursued.

(B) Twenty-five providers failing to complete the required training.

(2) For purposes of the definition of "systemic failure," failure by a physician who is not directly employed by the facility shall not be counted toward the percentage of providers failing to complete the required training where the facility demonstrates that the required training was offered to the physician, pursuant to subdivision (e).

(i) The Attorney General may post on their website a list of all facilities that did not timely submit proof of compliance pursuant to subdivision (f) or that were assessed penalties pursuant to subdivision (g). The Attorney General may include all of the following information when listing the facilities that were assessed penalties:

(1) The date the penalty was issued.

(2) The amount of the penalty.

(3) The reason the penalty was issued.

(4) The percentage of untrained providers.

(5) The date of facility noncompliance.

(j) The Attorney General may post on their internet website any other compliance data related to this article they deem appropriate.

(k) This section shall not be construed to limit the Attorney General from disclosing, on their internet website or otherwise, any information that they are otherwise not restricted from disclosing by any other provision of law.

(Amended by Stats. 2024, Ch. 621, Sec. 3. (AB 2319) Effective January 1, 2025.)

123630.4. (a) The State Department of Public Health shall track data on severe maternal morbidity, including, but not limited to, all of the following health conditions:

(1) Obstetric hemorrhage.

(2) Hypertension.

(3) Preeclampsia and eclampsia.

(4) Venous thromboembolism.

(5) Sepsis.

(6) Cerebrovascular accident.

(7) Amniotic fluid embolism.

(b) The data on severe maternal morbidity collected pursuant to subdivision (a) shall be published at least once every three years, after all of the following have occurred:

(1) The data has been aggregated by state regions, as defined by the State Department of Public Health, to ensure data reflects how regionalized care systems are or should be collaborating to improve maternal health outcomes, or other smaller regional sorting based on standard statistical methods for accurate dissemination of public health data without risking a confidentiality or other disclosure breach.

(2) The data has been disaggregated by racial and ethnic identity.

(c) The State Department of Public Health shall track data on pregnancy-related deaths, including, but not limited to, all of the conditions listed in subdivision (a), indirect obstetric deaths, and other maternal disorders predominantly related to pregnancy and complications predominantly related to the puerperium.

(d) The data on pregnancy-related deaths collected pursuant to subdivisions (a) and (c) shall be published, at least once every three years, after all of the following have occurred:

(1) The data has been aggregated by state regions, as defined by the State Department of Public Health, to ensure data reflects how regionalized care systems are or should be collaborating to improve maternal health outcomes, or other smaller regional sorting based on standard statistical methods for accurate dissemination of public health data without risking a confidentiality or other disclosure breach.

(2) The data has been disaggregated by racial and ethnic identity.

(Added by Stats. 2019, Ch. 533, Sec. 3. (SB 464) Effective January 1, 2020.)

123630.5. (a) A hospital, as defined in subdivision (a) of Section 1250, shall implement an evidence-based implicit bias program, as described in subdivision (b) of Section 123630.3, as part of its new graduate training program that hires and trains new nursing program graduates.

(b) If the hospital hires and trains new nursing program graduates who are subject to subdivision (c) of Section 123630.3, compliance by the hospital with Section 123630.3 shall meet the requirements of subdivision (a) only with respect to those new nursing program graduates subject to subdivision (c) of Section 123630.3.

(Added by Stats. 2021, Ch. 445, Sec. 3. (AB 1407) Effective January 1, 2022.)

123630.6. The Attorney General may publish a report outlining compliance data related to this article on a biennial basis. The report may be posted on the Attorney General's internet website.

(Added by Stats. 2024, Ch. 621, Sec. 4. (AB 2319) Effective January 1, 2025.)

123630.7. If any provision of the California Dignity in Pregnancy and Childbirth Act, or the application of any such provision to any person or circumstances, shall be held invalid, the remainder of the California Dignity in Pregnancy and Childbirth Act, to the extent it can be given effect, or the application of such provision to persons or circumstances other than those as to which it is held invalid, shall not be affected thereby, and to this end the provisions of the California Dignity in Pregnancy and Childbirth Act are severable.

(Added by Stats. 2024, Ch. 621, Sec. 5. (AB 2319) Effective January 1, 2025.)