

State of California
State and Consumer Services Agency

MEDICAL BOARD OF CALIFORNIA



MIDWIFERY ADVISORY COUNCIL

April 7, 2011



MEDICAL BOARD OF CALIFORNIA
Licensing Program



MEMBERS OF THE COUNCIL

Karen Ehrlich, L.M., Chair
Ruth Haskins, M.D., Vice Chair
William Frumovitz, M.D.
Faith Gibson, L.M.
Carrie Sparrevohn, L.M.
Barbara Yaroslavsky

**MIDWIFERY ADVISORY
COUNCIL**

April 7, 2011

Medical Board of California
Lake Tahoe Room
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(916) 263-2382

*Action may be taken on any item
listed on the agenda.*

AGENDA

12:00 p.m. – 2:30 p.m.
(or until conclusion of business)

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

1. **Call to Order/Roll Call**
2. **Public Comment on Items not on the Agenda**
Note: The Council may not discuss or take action on any matter raised during this public comment section that is not included on this agenda, except to decide whether to place the matter on the agenda of a future meeting. [Government Code Sections 11125, 11125.7(a)]
3. **Approval of Minutes from the December 9, 2010 Meeting**
4. **Midwifery Program Update – Ms. Thompson**
5. **Licensed Midwife Annual Report – Ms. Thompson**
 - A. Update on OSHPD / MBC Memorandum of Understanding
 - B. Update on Online 2010 Annual Report Survey
 - C. Update on Legislative Revision to Add Neonatal and Maternal Deaths to Statutory Reporting Requirements (Section 2516 of the Business and Professions Code) – Ms. Simoes
 - D. Update on MANA Statistics Project for the Mandated Collection of Midwifery Data
6. **Discussion and Possible Consideration of ACOG Legislative Agenda, District IX Proposals in Regard to Improving the Health Care and Outcomes for All California Pregnant Women – Dr. Haskins**

7. Update on Barriers to Care

- A. Lab Accounts – Ms. Robinson
- B. Discussion on Addressing Physician Supervision Via Regulations to Define the Appropriate Level of Supervision – Mr. Heppler
- C. Discussion on Pursuing Regulations in Order to Provide Authority for Licensed Midwives to Obtain Necessary Supplies – Mr. Heppler
- D. Status of Petition(s) Filed by Outside Entities to Change Regulations – Ms. Simoes

8. MAC Membership – Ms. Ehrlich

- A. Nominations to Fill MAC Termed Positions
 - 1) Licensed Midwife 3-Year Term (expires 2014)
 - 2) Public Member 3-Year Term (expires 2014)
- B. Discussion and Possible Consideration of Limits of Years/Terms for Council Members

9. Election of Officers for Term Beginning with August 2011 Meeting

10. Agenda Items for the August 11, 2011 meeting in Sacramento

11. Adjournment

The mission of the Medical Board of California is to protect healthcare consumers through the proper licensing and regulation of physicians and surgeons and certain allied healthcare professions and through the vigorous, objective enforcement of the Medical Practice Act, and to promote access to quality medical care through the Board's licensing and regulatory functions.

NOTICE: The meeting is accessible to the physically disabled. A person who needs disability-related accommodation or modification in order to participate in the meeting may make a request by contacting Cheryl Thompson at (916) 263-2393 or sending a written request to that person at the Medical Board of California, 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815. Providing your request at least five (5) business days before the meeting will help ensure availability of the requested accommodation.

Meetings of the Medical Board of California are open to the public except when specifically noticed otherwise in accordance with the Open Meeting Act. The audience will be given appropriate opportunities to comment on any issue presented in open session before the Board, but the Chair may apportion available time among those who wish to speak.

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For additional information call (916) 263-2393.



MEDICAL BOARD OF CALIFORNIA
Licensing Operations



Midwifery Advisory Council
Lake Tahoe Room
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

December 9, 2010

MINUTES

Agenda Item 1 Call to Order/Roll Call

The Midwifery Advisory Council (MAC) of the Medical Board of California was called to order by Chair Karen Ehrlich at 1:02 p.m. A quorum was present and notice had been mailed to all interested parties.

Members Present:

Karen Ehrlich, L.M., Chair
Ruth Haskins, M.D., Vice Chair
William Frumovitz, M.D.
Faith Gibson, L.M.
Carrie Sparrevohn, L.M.
Barbara Yaroslavsky

Staff Present:

Breanne Humphreys, Licensing Manager
Diane Ingram, Manager, Information Services Branch
Ryan Lam, Information Services Branch
Letitia Robinson, Manager, Licensing Operations
Jennifer Simoes, Chief of Legislation
Anita Scuri, Supervising Senior Counsel, Department of Consumer Affairs (DCA)
Cheryl Thompson, Analyst, Licensing Operations
Linda Whitney, Executive Director
Curt Worden, Chief of Licensing

Members of the Audience:

Bruce Ackerman, Midwives Alliance of North America (MANA)
Claudia Breglia, L.M., California Association of Midwives (CAM)
Mason Cornelius, Licensed Midwife
Frank Cuny, California Citizens for Health Freedom (CCHF)
Suchada Eickemeyer, Member of the Public
Megan Goldstein, Member of the Public
Jennifer Heystek, Licensed Midwife
Veronica Ramirez, California Medical Association
Jeff Toney, Division of Legislation and Policy Review, Department of Consumer Affairs

Agenda Item 2 Public Comments on Items Not on the Agenda

No public comments were offered.

Agenda Item 3 Approval of Minutes from the August 11, 2010, Meeting

Ms. Yaroslavsky made a motion to approve the minutes from the April 8, 2010 meeting; s/Sparrevohn; motion carried.

Agenda Item 4 Licensed Midwife Annual Report

A. Update on OSHPD / MBC Interagency Agreement

Diane Ingram, Manager, Information Services Branch, reported the Office of Statewide Health Planning Department (OSHPD) and the Board had been meeting to develop a multi-year Inter-Agency Agreement (IAA). The IAA has been transitioned to a Memorandum of Understanding (MOU) with no charges to be assessed to MBC by OSHPD for hosting the Licensed Midwife Annual Report (LMAR) on its website. The agreement is currently being reviewed by legal counsel.

B. Update on Online 2010 Annual Report Survey

Ms. Ingram reported the delivery of the 2010 LMAR to OSHPD has been delayed due to the testing of the extensive enhancements that were made to prevent reporting errors. It is anticipated that the report will be delivered on December 24, 2010 (a delay of approximately 5 weeks). The licensing file of midwives required to submit a report will also be delivered at that time. Once OSHPD has received the LMAR, they will begin their testing. It is anticipated the report will be available online to midwives sometime in February 2011.

Ms. Ingram introduced Ryan Lam, Associate Programmer Analyst, who has been making the requested enhancements to the LMAR. He provided a brief overview of these enhancements. It was requested that a safeguard be added that will not allow the user to save data into Section P unless she has previously reported a death in Section E. Although the LMAR has a definitions page and the definitions are incorporated in the directions for each section, it was requested that a pop up definition for "infant death" and "fetal demise" be added to the LMAR so the definition appears each time the user runs their mouse over that word.

Ms. Thompson reported a link to the LMAR will be placed on the midwife home page on the Board's website and a letter will be sent to all licensed midwives reminding them of the necessity of reporting and indicating the report is now available online with the due date. A paper version of the report will be available to those who request one, though this number has historically been small (8-10 midwives).

D. Consideration of Prospective Versus Retrospective Reporting of Data

Bruce Ackerman, Midwives Alliance of North America (MANA), reported they have a voluntary research oriented data collection system, called the MANA Statistics Project, that is capable of collecting and providing statistics on midwifery outcomes. It is burdensome for a midwife to report their data to both MANA and the relevant state data collection system (LMAR in California), so, currently, midwives may choose not to submit data to MANA. MANA has been in discussions with the state of Oregon to develop a simple model for reporting. Oregon licensed midwives will be asked to participate in the MANA Statistics Project and will satisfy their mandated reporting requirement by printing out a statistics page report and submitting it to their licensing authority. MANA will support this effort by revising their online data form to make it

shorter and less daunting to complete and developing a report that will satisfy Oregon's reporting requirements; this will be available online to Oregon midwives by July 2011. Mr. Ackerman would like to propose that a similar arrangement be developed for California. He stated this could be done at a minimal cost since the data is already being collected by MANA. Further, it would greatly aid in MANA's research efforts by providing a full representative sample of US midwives. Other states are also looking into the possibility of using MANA's Statistics Project for their mandated reporting, as well.

MANA has worked with the California Association of Midwives (CAM) to develop adjunct software to help midwives satisfy their reporting requirements in California; however, each time California or MANA's data forms change this software would have to be redone.

Ms. Sparrevohn explained that the California statistics are collected in a retrospective manner where results for the entire year are reported all at one time. In contrast, the MANA Statistics Project allows midwives to enter their data prospectively. When a midwife enrolls in the MANA program, she agrees to enter every client into the system. Each new client is registered and data is then entered for that client's outcomes. A consent form from clients is required since the data will be used for research purposes. This may create a reporting problem if the client refuses to sign the consent form. In such instances, MANA would still be able to report that there was a client who received services, but it would not be able to report the outcome of those services. The vast majority of the clients would, however, be reported in the statistics.

Dr. Haskins noted this consent requirement would have to be revamped for California reporting purposes since midwives must report outcomes for *every* client served. This issue is being worked on in the agreement with Oregon licensing. Mr. Ackerman was unsure if the consent form could be eliminated entirely, but stated it might be possible to use the information from a client who refused to sign the consent form for reporting purposes only, but not for research. This would be a matter for further discussion. Client confidentiality is preserved in that the client's name is never entered in the reporting; the midwife creates a code of her own design to use in assigning a number for each client. Dr. Haskins also noted the MANA Statistics Project includes data for midwives, most (but not all) of whom are licensed. Any reporting would have to exclude outcomes from unlicensed midwives.

The MANA Statistics Project is currently provided by MANA as a service to the profession at no cost to the midwives. Oregon is providing \$7,000 for the creation of the shortened reporting form. Mr. Ackerman stated he did not believe there would be any on-going funding from Oregon.

MANA does not actually conduct the research on midwifery outcomes, but maintains the registry as a database that can be used by other entities who are conducting research. Data has been collected since the early 1990s. Mr. Ackerman reported that any deaths reported in the MANA statistics are followed up with an interview.

Ms. Scuri suggested obtaining the elements of MANA's reports so these could be compared with California's reporting requirements to determine if there is value in changing California law to include these elements in place of what is currently being collected. Since the process in Oregon should be completed by July 2011, the MAC could have helpful information to consider at that time. Participation in the MANA program would provide a way to compare California midwifery data with that of other states.

Mr. Ackerman reported that, by the fall of 2011, California midwives who participate in the MANA Statistics Project should be able to print out a report that will assist them in completing the LMAR report submitted to OSHPD.

Mr. Ackerman stated that OSHPD would likely still be part of the reporting process in California. He suggested that midwives would use the MANA Statistics system on an on-going basis throughout the year. At the end of the year, the midwife would generate a report from the MANA system and submit it to OSHPD. OSHPD would then take these reports and aggregate the data into a summary report for MBC to submit to the Legislature.

Agenda Item 5 Discussion of Changes to the Midwifery Page on the Medical Board's Website

Ms. Thompson reported the Midwife License Application and a customized LiveScan form will soon be added to the website. As soon as it becomes available, a link to the 2010 LMAR and a helpful User Guide to the LMAR will also be added. While it would be desirable to provide the ability for midwives to renew their licenses online, the current system is limited and does not have this capability. The Department of Consumer Affairs (DCA) is undertaking a major IT project called BreEZe that will replace the current ATS Licensing and CAS Enforcement systems. Online renewals, as well as the ability for a midwife to check on the status of her application, will be possible with BreEZe. This new system is expected to roll out in December 2012.

Dr. Haskins asked about the possibility of editing the definition of "midwife" provided on the home page to remove the phrase "under the supervision of a licensed physician and surgeon, in active practice" or provide an asterisk and footnote to indicate the Board is aware that physician supervision is impossible due to liability issues, or anything else that would indicate this definition is not accurate in practice.

Ms. Scuri suggested it might be best to completely remove the second sentence outlining the scope of practice from the definition posted on the website. Ms. Whitney indicated this would have to be reviewed.

Agenda Item 6 Program Update

Ms. Thompson directed members to page 15 of their packets for the midwifery licensing statistics for the first quarter of FY 2010/2011. During this period, 9 new midwife licenses were issued and 30 licenses were renewed. Since the end of October 2010, 12 additional midwife licenses have been issued, bringing the total number of new midwives up to 21. This number already surpasses the totals for all of FY 2009/2010 when 19 licenses were issued.

On Wednesday, February 16, 2011, approximately 15 midwifery candidates will sit for the NARM exam at the Medical Board's offices. This exam, which is offered twice per year, satisfies the Board's written examination requirement for licensure.

Agenda Item 7 Discussion on Title 16 California Code of Regulations Section 1379.30 and Effect of Sunset of Former Business and Professions Code Section 2514

Ms. Scuri reported that Ms. Ehrlich had voiced concern with the sunset of B&P Code Section 2514 which outlined the educational requirements for midwifery education programs. When this section of law was allowed to sunset, it was transferred verbatim into regulation as Title 16 of the CCR

Section 1379.30. This section includes the practices an education program must prepare a midwife to perform, including the administration of intravenous fluids, analgesics, postpartum oxytocics and RhoGAM, administration of local anesthesia, paracervical blocks, pudendal blocks, local filtration, episiotomy and episiotomy repair, Vitamin K and eye prophylaxis, among others.

Ms. Scuri noted for other professions, these regulations might reflect scope of practice; however, she suggested it might be preferable if there were a regulation that specifically listed those duties a midwife may perform, even though they are within a midwife's scope of practice under the midwifery law and this was the intent of the regulation. B&P Section 2507 states that a license to practice midwifery authorizes the holder under the supervision of a licensed physician and surgeon to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family planning for the mother and immediate care for the newborn. The items listed in the regulation are essential components of a midwife being able to carry out the duties authorized in law. Ms. Scuri stated the midwifery law authorizes midwives to perform those actions and carry out those procedures.

Ms. Sparrevohn stated that the way the regulation was written, it does not provide any authority for midwives to obtain analgesics, oxytocics, etc. This creates a barrier for midwives in obtaining these needed items.

Dr. Haskins noted that Section 1379.30(e) which requires approved midwifery education programs to prepare midwives to provide management of family planning and routine gynecological care including barrier methods of contraception such as diaphragms and cervical caps, is an issue for the obstetrician and gynecologist communities. They believe midwives who perform such functions are overstepping their bounds and, were this to become more widely recognized and practiced, is likely to be vehemently challenged by the American Congress of Obstetricians and Gynecologists and the California Medical Association. Dr. Haskins clarified that "routine gynecological care" in her mind, would include the annual health maintenance exam including pap smear, breast check and thyroid check.

Ms. Sparrevohn stated the midwife scope of practice is identical to that for licensed certified nurse midwives (CNM); no one would contest that CNM may conduct health maintenance exams as part of routine gynecological care. She reported she works in exactly the same manner as a CNM, with the only difference being her inability to call in a prescription under her own name.

Dr. Frumovitz stated years ago, when gynecologists were confronted by family practitioners and internists doing routine gynecological care, they fought this fiercely. He reported there is a need to educate the obstetrician/gynecological community as to the capabilities and services midwives provide, rather than arguing about a sentence in the law.

Ms. Ehrlich asked, in Dr. Haskin's opinion, if the midwives were to leave routine gynecological care as taking place under the supervision of a physician or surgeon (rather than under independent midwifery practice), would licensed midwives be able to be hired in clinics and other such facilities to perform annual, routine health maintenance exams for women and would this be acceptable to physicians.

Dr. Haskins stated she thought this would be true. Most physicians believe there cannot be independent practice of midwifery and that it must be under physician supervision.

Agenda Item 8 Terms and Conditions of Probation

Ms. Whitney stated that at the previous MAC meeting she had reported that there had not been an opportunity to look at the terms and conditions of probation as they might apply to midwives. She directed members to pages 16 of their packets for the Manual of Model Disciplinary Guidelines that were established for physicians. The Guidelines are currently being revised by the Board; a hearing on the revised Guidelines will take place at the January 2011 Board meeting. Rather than discussing terms and conditions of probation as they relate to midwifery at this meeting, Ms. Whitney asked to postpone this discussion until the revised Guidelines have been adopted. She requested that the Council appoint a member to work with Ms. Robinson, Ms. Thompson, and legal counsel to pull out and discuss the appropriate sections of the Disciplinary Guidelines that could apply to midwives and then present at a future meeting for discussion. Ms. Gibson volunteered to serve in this capacity.

Agenda Item 9 Update on Barriers to Care

Ms. Simoes reported she was charged with meeting with the various state agencies to determine if there were any changes that could be implemented without statutory or regulatory authority to address identified barriers to care. Ms. Simoes, Mr. Worden, and Ms. Thompson met with the California Department of Public Health (CDPH) on several issues noted under barriers to care. Issues surrounding birth certificates include each county creating its own rules and worksheets, midwives' being unable to submit birth information electronically, register births within 10 days, and obtain social security numbers automatically.

Lynette Scott, the State Registrar, met with Medical Board staff and provided information on constraints the state and counties are facing. Per CDPH, out of hospital births have issues related to security concerns. Since the 9/11 terrorism acts and the increase in identity theft, there has been increased attention to birth certificates at both the state and federal level. Birth certificates are considered potential "breeder documents" opening the door to many other potential abuses. Birth certificate security is, therefore, considered a critical first line defense. Counties take on considerable liability when they register a birth to ensure that the birth really did occur. Heightened security extends to the paper being used for the certificates, the way the information is recorded by the counties, etc. This is of particular concern in jurisdictions along the Mexican border since the birth certificate is the key document used to establish citizenship. This is why some counties may have tighter requirements and rules than others.

A guide on how to register an out of hospital birth is located on CDPH's website; this lists the state requirements. Each county tries to meet the state requirements in a different way, hence the variation from county to county. The State Registrar does not dictate exactly how the requirements are to be met.

The Automatic Vital Statistics System (AVSS) is used to electronically register births. The Registrar reviewed the requirements for using the system with staff; these requirements are spelled out at www.avss.ucsb.edu. As the local registrar is accountable for the information they record, independent use of AVSS for registering out of hospital births has additional requirements. These include purchasing a license from UCSB, performing training on the system, purchasing the required hardware including a special printer, maintaining numbered birth certificate paper in a locked environment, and receiving approval from the State Registrar's Office. These requirements pose a significant expense for an independent midwife interested in registering births electronically. Further, the Social Security Administration has issued a federal guideline that

specifies that if the AVSS system is used to establish a social security number, the birth must have occurred in a hospital.

Ms. Yaroslavsky suggested that at some point in the future it might be feasible for the licensing of midwives, registration and reporting of individual birth data by MANA and OSHPD, and the registration of births with counties to be integrated.

Ms. Simoes noted any such requirements would also have to be matched against not only state but federal requirements.

With regard to the law requiring that births be registered within 10 days, Ms. Simoes noted, while this is in law, there is no way for the State Registrar to enforce this. She stated that having uniform practices for registering out of hospital births across all California counties would require a change in law, as counties are currently permitted to establish their own procedures as long as they meet the state requirements.

The next barrier to care addressed dealt with the difficulty midwives face in obtaining lab accounts with diagnostic laboratories due to the CDPH's Laboratory Field Service's determination. Staff spoke with the Beatrice O'Keefe, Division Chief, Laboratory Field Services (LFS). Ms. O'Keefe stated that any healing art licensee has the authority to open and maintain lab accounts, including licensed midwives. She stated the difficulty licensed midwives are facing are primarily due to lack of education among diagnostic laboratory staff. LFS is willing to work with MAC to get the information out to the labs. Staff was invited to the upcoming Clinical Laboratory Technology Advisory Committee (CLTAC) meeting on January 14, 2011 in Richmond to address this issue.

Ms. Ehrlich asked that a letter be requested from Ms. O'Keefe that can be sent to every licensed midwife to be presented if they are denied a lab account.

Ms. Simoes suggested that a collaborative approach might be more effective, where labs are given the opportunity to respond once they have received education from LFS.

Ms. Whitney stated, with MAC's permission, that the Board will send a written request to LFS asking for a written response that could be distributed to licensed midwives. In addition, the Board will send a representative to the CLTAC meeting in January.

Claudia Breglia, CAM, thanked Ms. Simoes for her efforts. Previous correspondence from LFS to the labs indicated just the opposite, that licensed midwives required a supervising physician's signature on file in order to open an account. She requested that any letter from LFS reference this prior direction as being inaccurate, since labs cite this correspondence in denying accounts. Dr. Haskins warned that by opening lab accounts, licensed midwives will be subject to certification requirements for performing certain tests. In addition CLIA waived tests may require completing voluminous paperwork and paying a fee to the state and federal government for the ability to perform them.

Ms. Simoes reported the other previously reported barriers to care would require regulatory changes. In her discussion with CDPH, she was told that any changes to the Comprehensive Perinatal Services Program (CPSP) (such as adding midwives to the approved provider list) would require a change in regulations. CDPH indicated they were very behind in their regulations; further, they have a different regulatory approval process that would require approval from "higher

up” before they could move forward. Ms. Simoes was told it would take at least 2 years for any regulatory change to become possible. It is possible that Federal Health Care Reform may resolve this issue.

Ms. Scuri reported there is a provision in the rulemaking law that allows a member of the public to petition any state agency to change a regulation. DCA’s website contains a rulemaking manual that outlines the requirements for petitioning for a change in regulations. The statutory response time, to either deny or set the matter for hearing, is set in law. Such rules do not exist for one state department to petition another state department. Ms. Scuri suggested the best route would be for one of the midwifery organizations or groups to petition CDPH for the regulatory change.

Ms. Simoes noted a petition from midwifery organizations to CDPH could be used to address both the Alternative Birth Center regulations and the CPSP; a petition to the Managed Risk Medical Insurance Board could be made to address changes to the Access for Infants and Mother’s Program.

Agenda Item 10 Discussion on Membership of Midwifery Advisory Council

Ms. Ehrlich requested that, in the future, should there be a public member opening on the MAC, consideration be given to filling the vacancy with a member of the public who has been a recipient of midwifery services.

Ms. Scuri noted the number of members on the Council is not set in law; this was set by the Medical Board when the MAC was first implemented and could be changed. The statute specifies that half of the members shall be California licensed midwives. Increasing the size of the Council would be allowable under current law.

As the Council currently consists of 6 members, three of which are midwives, this would entail adding two more members to the MAC (one public and one licensed midwife). Given budget constraints, Ms. Ehrlich indicated she did not think this would be approved, even though the Council operates at a relatively minimal cost to the Board.

Dr. Haskins noted that, over the years, she has seen consensus among the public members and midwives, rather than split votes. She takes this as evidence that the composition is not critical. Further, she stated that the MAC generally has excellent audience participation such that issues of concern to midwives or the public (including parents who are recipients of midwifery care) are voiced and those opinions entered into the public record. In the issues that have been addressed by the MAC over the years, Dr. Haskins stated she cannot recall a single instance where she wished there were a member who had used a midwife sitting on the MAC to provide their input.

Ms. Ehrlich was concerned that opportunities for parents to participate and have a voice in the workings of the Council were very limited. She stated the public member slot filled by one of the physicians was often empty, the physician choosing not to stay and commit to the Council. She stated she has no issues with the current public members, but, should one of them choose to step down that consideration be given to filling their slot with a parent.

Ms. Gibson stated she felt all the Council members did a good job of representing what is most important and beneficial to midwives; she thought the perspective of someone who actually uses midwifery services may be different and is missing from the current Council.

Agenda Item 11 Discussion on VBAC (Title 16 California Code of Regulations Section 1379.19(b))

Ms. Scuri reported there have been extensive discussions about vaginal birth after cesarean section (VBAC) when the Midwifery Standards of Care were being created. Title 16 CCR Section 1379.19 places the Standards of Care into regulation and has an entire section on VBAC and when a midwife can provide services to a client who has previously had a C-section. If the client meets the criteria set forth in the Standards of Care, then the midwife must provide the client with informed consent and document this in the client's midwifery record.

Dr. Frumovitz stated VBACs are a controversial and sensitive issue, particularly with the cesarean section rate now at 33% and growing and some hospitals refusing to perform VBACs. He noted that physicians are being held to one standard and midwives practicing at home are held to a different standard, which does not seem appropriate.

Ms. Erlich noted that the practice of midwifery is not the practice of medicine. There are distinctions in the standards and philosophies that differ. She stated she sees this as a denial of care issue and it is far preferable for a midwife to have a VBAC with a midwife present than have an unassisted home birth. Ms. Ehrlich reported the ACOG guidelines state there shall be no forced surgery and that women have the option of informed choice.

Dr. Haskins noted the Standard of Care incorporating VBACs was established before the existence of the MAC; it was decided by the Midwifery Committee of the Medical Board, with vocal input from ACOG representatives. The final determination that the Medical Board agreed with rested on the client's right to self-determination. The Administrative Law judge who reviewed the scope as presented in the regulations agreed. Very specific criteria must be met, including advising the client that ACOG recommends a hospital birth, informing her how many VBACs the midwife has performed and the level of her training and competence. If the client acknowledges all of this in writing and still wants to deliver at home, then she has that option.

Ms. Breglia distributed a copy of the Midwifery Standard of Care and the ACOG Practice Bulletin No. 54 from July 2004. This document has been superseded by ACOG Practice Bulletin No. 115 from August 2010, which states that:

“In addition to fulfilling a patient's preference for vaginal delivery, at an individual level VBAC is associated with decreased maternal morbidity and a decreased risk of complications in future pregnancies. At a population level, VBAC also is associated with a decrease in the overall cesarean delivery rate. Although TOLAC is appropriate for many women with a history of cesarean delivery, several factors increase the likelihood of a failed trial of labor, which compared with VBAC, is associated with increased maternal and perinatal morbidity. Assessment of individual risks and the likelihood of VBAC is, therefore, important in determining who are appropriate candidates for TOLAC.”

Ms. Breglia noted midwives take this evaluation very seriously; many midwives will not take on a client with multiple cesareans, or a primary VBAC with twins (even though Practice Bulletin No. 115 states there is not an increased risk with twins or after two previous cesareans).

A copy of the Annals of Family Medicine 4:228-234 (2006) “*Vaginal Birth After Cesarean in California: Before and After a Change in Guidelines*” was also distributed by Ms. Breglia. This report showed the number of attempted VBACs decreased sharply in 1999 after ACOG adopted

more restrictive guidelines for VBACs, but the neonatal and maternal mortality rates did not change during this period. The conclusion was that neonatal and maternal mortality rates did not improve despite increasing rates of cesarean delivery.

Dr. Haskins noted the importance of the 9 months of communication and the establishment of a relationship between the midwife and the client in making decisions on care. If a midwife transfers a patient to the hospital, the physician does not have the benefit of that prior communication and relationship and must follow hospital protocol. She noted it is often the hospital's decision, not the individual physician's, on whether to allow TOLAC and accept the liability for a ruptured uterus.

Agenda Item 12 Agenda Items for Next MAC Meeting

Suchada Eickemeyer, member of the public, reported she had both her children with the help of midwives. She stated the process of obtaining a birth certificate and social security number was onerous and took almost 6 months.

Ms. Gibson stated she has been told by her local Social Security Office that they will not accept a birth certificate that indicates a home birth as documentation. This can create great difficulty for a low income mother trying to get a social security number in order to enroll her child in federal assistance services. Correcting this would require congressional intervention, not state intervention.

Dr. Haskins asked that an agenda item be added on the implementation of the Obama Health Care Reform from a CMA and ACOG perspective to help update the Council and interested individuals on movement toward collaboration.

Ms. Sparrevohn requested an update on the lab accounts and the CLTAC meeting.

A member of the audience requested that the difficulty some midwives face in securing a back up physician for women choosing out of hospital births be placed on the agenda. Dr. Haskins stated ACOG was moving in a positive direction toward collaboration between licensed gynecologists backing midwives in a way that is acceptable to both and she will provide information at the next Council meeting.

Ms. Ehrlich requested discussion on strategies to resolve the physician supervision issue, including possibly defining of the appropriate level of supervision. This discussion item may be tabled depending upon the content of Dr. Haskin's report.

Ms. Yaroslavsky requested that future MAC meetings start at an earlier time to accommodate flight schedules while still allowing sufficient time for driving time.

Agenda Item 13 Adjournment

Meeting adjourned at 3:12 p.m.

MIDWIFERY PROGRAM LICENSING STATISTICS

Licensed Midwives	FY 10/11	Q1	Q2	Q3	Q4
Applications Received	23	12	11		
Applications Pending	N/A	4	1		
Licenses Issued	25	9	13		
Licenses Renewed	47	30	17		
Licenses Cancelled	0	0	0		

Licensed Midwives	FY 09/10	Q1	Q2	Q3	Q4
Applications Received	16	2	0	10	4
Applications Pending	N/A	N/A	1	0	2
Licenses Issued	19	2	2	10	5
Licenses Renewed	74	18	4	29	23
Licenses Cancelled	0	0	0	0	0

Total Number of Midwives (as of 3/6/11)	
Renewed / Current Status	240
Delinquent Status	19

CALIFORNIA LICENSED MIDWIFE ANNUAL REPORT

SECTION A - LICENSEE DATA

1a. First:	1b. Middle:	1c. Last:	
2. License Number:			
<i>Numbers 3-10 are voluntary, but will assist OSHPD in contacting you if questions arise relating to your report.</i>			
3. Street Address 1:			
4. Street Address 2:			
5. City:	6. State:	7. ZIP Code:	
8. Phone 1:	9. Phone 2:		
10. E-mail Address:			

SECTION B - REPORTING PERIOD

Line No.	Report Year
11	

SECTION C - SERVICES PROVIDED IN CALIFORNIA

Line No.		Yes	No
12	Did you or a student midwife supervised by you perform midwife services in the State of California during the year when the intended place of birth at the onset of your care was an out-of-hospital setting?		

SECTION D - CLIENT SERVICES

Lines 13 to 17: Client Services include all clients for whom you provided midwifery services in this reporting year, whose intended place of birth at the onset of **YOUR** care was an out-of-hospital setting. Include all clients regardless of year initially booked.

Line No.		Total #
13	Total number of clients served as primary caregiver during this calendar year.	
14	Number of clients who left care for a non-medical reason. (DO NOT include these clients in any further categories on this report)	
15	Total number of clients served whose births were still pending on the last day of this reporting year.	
16	Enter the number of clients served who also received collaborative care. IMPORTANT: SEE DEFINITION OF COLLABORATIVE CARE!	
17	Enter the number of clients served under the supervision of a licensed physician and surgeon IMPORTANT: SEE DEFINITION OF SUPERVISION!	

SECTION E - OUTCOMES PER COUNTY IN WHICH BIRTH, FETAL DEMISE, OR INFANT OR MATERNAL DEATH OCCURRED

Lines 18a to 18g: Include all births, cases of fetal demise, and infant and maternal deaths that occurred during this reporting year, regardless of year client was initially booked.

Column A: Enter each county - use the county codes provided from the dropdown list - where you attended a birth as the primary caregiver or had a client whose pregnancy resulted in a fetal demise discovered while under your care.

Column B: Enter the number of clients in that county whose pregnancies resulted in a live birth while under your care.

Column C: Enter the number of clients in that county whose pregnancies resulted in a fetal demise discovered while under your care.

Column D: Enter the number of clients in that county whose pregnancies resulted in an infant death while under your care.

Column E: Enter the number of clients in that county whose pregnancies resulted in a maternal death while under your care.

Line No.	(A) County in which the Birth Occurred, or Fetal Demise or Death was discovered (see county code list)	(B) # of Live Births	(C) # of Cases Fetal Demise Discovered while Client was Under Your Care	(D) # of Cases of Infant Death While Under Your Care	(E) # of Cases of Maternal Death While Client was Under Your Care
18a					
18b					
18c					
18d					
18e					
18f					
18g					

SECTION F - OUTCOMES OF OUT-OF-HOSPITAL BIRTHS

Lines 19 to 24: Include all births that occurred during this reporting year, regardless of year client was initially booked. It is understood that for this section each birth experience or infant born may be included on more than one line.

DELIVERY: episode of a mother giving birth regardless of number of babies born alive or dead.

Line 19: Enter total number of out-of-hospital deliveries you planned on attending as the primary caregiver at the onset of labor

Line 20: Out of the total number of out-of-hospital births you planned on attending as the primary caregiver at the onset of labor (as indicated in line 19), enter the number of those deliveries that actually did occur in an out-of-hospital setting

Line 21: Enter the number of planned deliveries you attended in an out-of-hospital as the primary caregiver that were delivered breech.

Line 22: Enter the number of planned deliveries you attended in an out-of-hospital setting as the primary caregiver who delivered vaginally after having a prior cesarean section (VBAC).

Lines 23: Enter the number of planned deliveries you attended in an out-of-hospital as the primary caregiver that involved twins. Each mother giving birth counts as one delivery, regardless of number of babies born. Record only if all babies delivered out-of-hospital.

Lines 24: Enter the number of planned deliveries you attended in an out-of-hospital setting as the primary caregiver that involved a high number of multiples. Each mother giving birth counts as one delivery, regardless of number of babies born. Record only if all babies delivered out-of-hospital.

Line No.		Total #
19	Number of planned out-of-hospital births at the onset of labor	
20	Number of completed births in an out-of-hospital setting	
21	Breech deliveries	
22	Successful VBAC's	
23	Twins both delivered out-of-hospital	
24	Higher Order Multiples - all delivered out-of-hospital	

SECTION G - ANTEPARTUM TRANSFER OF CARE, ELECTIVE/NON-EMERGENCY

Lines 25-44: For each reason listed, enter the number of clients who, during the antepartum period electively (no emergency existed) transferred to the care of another healthcare provider. Report the primary reason for each client.

Line No.	Code	Reason	Total #
25	G1	Medical or mental health conditions <i>unrelated</i> to pregnancy	
26	G2	Hypertension developed in pregnancy	
27	G3	Blood coagulation disorders, including phlebitis	
28	G4	Anemia	
29	G5	Persistent vomiting with dehydration	
30	G6	Nutritional & weight loss issues, failure to gain weight	
31	G7	Gestational diabetes	
32	G8	Vaginal bleeding	
33	G9	Suspected or known placental anomalies or implantation abnormalities	
34	G10	Loss of pregnancy (includes spontaneous and elective abortion)	
35	G11	HIV test positive	
36	G12	Suspected intrauterine growth restriction, suspected macrosomia	
37	G12.1	Fetal anomalies	
38	G13	Abnormal amniotic fluid volumes; oligohydramnios or polyhydramnios	
39	G14	Fetal heart irregularities	
40	G15	Non vertex lie at term	
41	G16	Multiple gestation	
42	G17	Clinical judgment of the midwife (where a single other condition above does not apply)	
43	G18	Client request	
44	G19	Other	
G19 Explanation			

SECTION H – ANTEPARTUM TRANSFER OF CARE, URGENT/EMERGENCY

Lines 45-54: For each reason listed, enter the number of clients who, during the antepartum period, were transferred to the care of another healthcare provider due to an urgent or emergency situation. Report only the primary reason for each client.

Line No.	Code	Reason	Total #
45	H1	Non pregnancy-related medical condition	
46	H2	Severe or persistent headache, pregnancy-induced hypertension (PIH), or preeclampsia	
47	H3	Isoimmunization, severe anemia, or other blood related issues	
48	H4	Significant infection	
49	H5	Significant vaginal bleeding	
50	H6	Preterm labor or preterm rupture of membranes	
51	H7	Marked decrease in fetal movement, abnormal fetal heart tones, non-reassuring non-stress test (NST)	
52	H8	Fetal demise	
53	H9	Clinical judgment of the midwife (where a single other condition above does not apply)	
54	H10	Other	
H10 Explanation			

SECTION I – INTRAPARTUM TRANSFER OF CARE, ELECTIVE/NON-EMERGENCY

Lines 55-67: For each reason listed, enter the number of clients who, during the intrapartum period, electively (no emergency existed) transferred to the care of another healthcare provider. Report only the primary reason for each client.

Line No.	Code	Reason	Total #
55	I1	Persistent hypertension; severe or persistent headache	
56	I2	Active herpes lesion	
57	I3	Abnormal bleeding	
58	I4	Signs of infection	
59	I5	Prolonged rupture of membranes	
60	I6	Lack of progress; maternal exhaustion; dehydration	
61	I7	Thick meconium in the absence of fetal distress	
62	I8	Non-vertex presentation	
63	I9	Unstable lie or mal-position of the vertex	
64	I10	Multiple gestation (NO BABIES DELIVERED PRIOR TO TRANSFER)	
65	I11	Clinical judgment of the midwife (where a single other condition above does not apply)	
66	I12	Client request; request for medical methods of pain relief	
67	I13	Other	

SECTION J – INTRAPARTUM TRANSFER OF CARE, URGENT/EMERGENCY

Lines 68-76: For each reason listed, enter the number of clients who, during the intrapartum period, were transferred to the care of another healthcare provider due to an urgent or emergency situation. Report only the primary reason for each client.

Line No.	Code	Reason	Total #
68	J1	Suspected preeclampsia, eclampsia, seizures	
69	J2	Significant vaginal bleeding; suspected placental abruption; severe abdominal pain inconsistent with normal labor	
70	J3	Suspected uterine rupture	
71	J4	Maternal shock, loss of consciousness	
72	J5	Prolapsed umbilical cord	
73	J6	Non-reassuring fetal heart tones and/or signs or symptoms of fetal distress	
74	J7	Clinical judgment of the midwife (where a single other condition above does not apply)	
75	J8	Other life threatening conditions or symptoms	
76	J9	Multiple gestation (AT LEAST ONE BABY HAS BEEN DELIVERED OUT-OF-HOSPITAL)	

SECTION K – POSTPARTUM TRANSFER OF CARE - MOTHER, ELECTIVE/NON-EMERGENCY

Lines 77-85: For each reason listed, enter the number of clients who, during the postpartum period, electively (no emergency existed) transferred to the care of another healthcare provider. Report only the primary reason for each client.

Line No.	Code	Reason	Total #
77	K1	Adherent or retained placenta without significant bleeding	
78	K2	Repair of laceration beyond level of midwife's expertise	
79	K3	Postpartum depression	
80	K4	Social, emotional or physical conditions outside of scope of practice	
81	K5	Excessive or prolonged bleeding in later postpartum period	
82	K6	Signs of infection	
83	K7	Clinical judgment of the midwife (where a single other condition above does not apply)	
84	K8	Client request	
85	K9	Other	
K9 Explanation			

SECTION L – POSTPARTUM TRANSFER OF CARE - MOTHER, URGENT/EMERGENCY

Lines 86-94: For each reason listed, enter the number of clients who, during the postpartum period, were transferred to the care of another healthcare provider due to an urgent or emergency situation. Report only the primary reason for each client.

Line No.	Code	Reason	Total #
86	L1	Abnormal or unstable vital signs	
87	L2	Uterine inversion, rupture or prolapse	
88	L3	Uncontrolled hemorrhage	
89	L4	Seizures or unconsciousness, shock	
90	L5	Adherent or retained placenta with significant bleeding	
91	L6	Suspected postpartum psychosis	
92	L7	Signs of significant infection	
93	L8	Clinical judgment of the midwife (where a single other condition above does not apply)	
94	L9	Other	
L9 Explanation			

SECTION M – TRANSFER OF CARE - INFANT, ELECTIVE/NON-EMERGENCY

Lines 95-102: For each reason listed, enter the number of infants who electively (no emergency existed) transferred to the care of another healthcare provider. Report only the primary reason for each infant.

Line No.	Code	Reason	Total #
95	M1	Low birth weight	
96	M2	Congenital anomalies	
97	M2.1	Birth injury	
98	M3	Poor transition to extrauterine life	
99	M4	Insufficient passage of urine or meconium	
100	M5	Parental request	
101	M6	Clinical judgment of the midwife (where a single other condition above does not apply)	
102	M7	Other	
M7 Explanation			

SECTION N – TRANSFER OF CARE - INFANT, URGENT/EMERGENCY

Lines 103-115: For each reason listed, enter the number of infants who were transferred to the care of another healthcare provider due to an urgent or emergency situation. Report only the primary reason for each infant.

Line No.	Code	Reason	Total #
103	N1	Abnormal vital signs or color, poor tone, lethargy, no interest in nursing	
104	N2	Signs or symptoms of infection	
105	N3	Abnormal cry, seizures or loss of consciousness	
106	N4	Significant jaundice at birth or within 30 hours	
107	N5	Evidence of clinically significant prematurity	
108	N6	Congenital anomalies	
109	N6.1	Birth injury	
110	N7	Significant dehydration or depression of fontanelles	
111	N8	Significant cardiac or respiratory issues	
112	N9	Ten minute APGAR score of six (6) or less	
113	N10	Abnormal bulging of fontanelles	
114	N11	Clinical judgment of the midwife (where a single other condition above does not apply)	
115	N12	Other	
N12 Explanation			

SECTION O – BIRTH OUTCOMES AFTER TRANSFER OF CARE

Lines 116-131: For any mother or infant with transfer of care Reported in section I, J, K, L, M and N, from the licensed midwife to another healthcare provider, please provide the outcome information regarding both the mother and for the infant in the spaces provided.

Line No.	Reason	(A)Total # ofVaginal Births	(B)Total # ofCaesarean Deliveries
MOTHER		Code	Code
116	Without complication	O1	O8
117	With serious pregnancy/birth related medical complications resolved by 6 weeks	O2	O9
118	With serious pregnancy/birth related medical complications <u>not</u> resolved by 6 weeks	O3	O10
119	Death of mother	O4	O11
120	Unknown	O5	O12
121	Information not obtainable	O6	O13
122	Other	O7	O14
O5 Explanation			
O6 Explanation			
O7 Explanation			
O12 Explanation			
O13 Explanation			
O14 Explanation			
INFANT			
123	Healthy live born infant	O15	O24
124	With serious pregnancy/birth related medical complications resolved by 4 weeks	O16	O25
125	With serious pregnancy/birth related medical complications <u>not</u> resolved by 4 weeks	O17	O26
126	Fetal demise diagnosed prior to labor	O18	O27
127	Fetal demise diagnosed during labor or at delivery	O19	O28
128	Live born infant who subsequently died	O20	O29
129	Unknown	O21	O30
130	Information not obtainable	O22	O31
131	Other	O23	O32
O21 Explanation			
O22 Explanation			
O23 Explanation			
O30 Explanation			
O31 Explanation			
O32 Explanation			

SECTION P – COMPLICATIONS LEADING TO MATERNAL AND/OR INFANT MORTALITY

Only complete this section if you reported instances of infant or maternal deaths in previous sections! This section is NOT designed to report or include fetal demise or stillbirths.

Lines 132-138: For each complication listed, in Column A, enter the total number of mothers who died during the pregnancy or within six (6) weeks after the end of a pregnancy as a result of that complication. Indicate in Columns A or B the numbers that were out-of-hospital births or transfers. Report only one primary complication for each client.

Lines 139-146: Indicate in Columns A or B the numbers that were out-of-hospital births or transfers. Report only one primary complication for each client.

Line No.	Complication	Out-of-Hospital (A)		After Transfer (B)		Total # from (A) and (B) (C)	
		Code		Code		Code	
MOTHER							
132	Blood loss	P8		P15		P1	
133	Sepsis	P9		P16		P2	
134	Eclampsia/toxemia or HELLP syndrome	P10		P17		P3	
135	Embolism (pulmonary or amniotic fluid)	P11		P18		P4	
136	Unknown	P12		P19		P5	
137	Information not obtainable	P13		P20		P6	
138	Other	P14		P21		P7	
P12 Explanation							
P13 Explanation							
P14 Explanation							
P19 Explanation							
P20 Explanation							
P21 Explanation							
INFANT							
139	Anomaly incompatible with life	P30		P38		P22	
140	Infection	P31		P39		P23	
141	Meconium aspiration, other respiratory	P32		P40		P24	
142	Neurological issues/seizures	P33		P41		P25	
143	Other medical issue	P34		P42		P26	
144	Unknown	P35		P43		P27	
145	Information not obtainable	P36		P44		P28	
146	Other	P37		P45		P29	
P35 Explanation							
P36 Explanation							
P37 Explanation							
P43 Explanation							
P44 Explanation							
P45 Explanation							

The information contained herein is accurate and complete to the best of my knowledge.

Signature:

Date:

Please send the completed report to:

Office of Statewide Health Planning and Development
Patient Data Section
Licensed Midwife Annual Report
400 R Street, Suite 270
Sacramento, CA 95811-6213

Appendix A - County Code List

County Name	
ALAMEDA	ORANGE
ALPINE	PLACER
AMADOR	PLUMAS
BUTTE	RIVERSIDE
CALAVERAS	SACRAMENTO
COLUSA	SAN BENITO
CONTRA COSTA	SAN BERNARDINO
DEL NORTE	SAN DIEGO
EL DORADO	SAN FRANCISCO
FRESNO	SAN JOAQUIN
GLENN	SAN LUIS OBISPO
HUMBOLDT	SAN MATEO
IMPERIAL	SANTA BARBARA
INYO	SANTA CLARA
KERN	SANTA CRUZ
KINGS	SHASTA
LAKE	SIERRA
LASSEN	SISKIYOU
LOS ANGELES	SOLANO
MADERA	SONOMA
MARIN	STANISLAUS
MARIPOSA	SUTTER
MENDOCINO	TEHAMA
MERCED	TRINITY
MODOC	TULARE
MONO	TUOLUMNE
MONTEREY	VENTURA
NAPA	YOLO
NEVADA	YUBA

Appendix B – Frequently Asked Questions

What happens if I am out of town and the midwife covering my practice transports one of my clients. Who reports?

If you are the primary midwife and are away or otherwise temporarily leave your clients in the care of a back-up midwife and that midwife ends up transferring your client, you should be the midwife who reports that transfer. This does not apply if you transfer care permanently to the other midwife, only for temporary coverage situations.

I have clients that live and plan to give birth in Nevada, but I occasionally provide care to these clients in my California Office. Should I report this as “care given in California”?

Only report on clients who intended to have you attend their out of hospital birth in California, regardless of what state the midwife was in when you provided their prenatal care.

With regard to fetal demise in Section E, if the fetus has a documented heartbeat when we left for the hospital but doesn't when we get there or has a heartbeat when we arrive at the hospital but dies later, would I report the county in which I discovered the fetal demise?

No, you did not discover the fetal demise while it was under your care and it should not be reported in Section E. In Section E, only enter instance of fetal demise that were discovered under your care. If you don't hear a heartbeat during a prenatal visit or during labor and the demise is confirmed after transfer, you have discovered the demise while under your care and it should be entered in this section.

I'm confused by Line 13 since it includes people who have been or will be reported on in other years. Who should I include in this number?

Only include care given in California. This line should include all the clients who were seen for prenatal care during 2010 but left care for any reason before the baby was born, all the clients who had their babies in 2010 whether at home or after transport, and all clients you saw prenatally in 2010 who had not had their babies yet at the end of the year. This number should only include clients who entered care intending an out of hospital birth and does not include clients seen for well woman care only, doula clients, or clients who intended a hospital birth but wanted additional prenatal care with a midwife. It does *not* include clients who were still being seen for postpartum care in 2010 after having babies in 2009.

If I send the baby to the doctor because of a concern, but also continue to provide care for the baby at home, do I report that a transfer of care for a newborn?

If you are unsure about a baby and bring it to a pediatrician who pronounces everything fine and returns the baby to your care, that is not a transfer and should not be reported in Sections M or N. If you bring the baby in and after examination the medical caregiver decides to admit the baby for observation or decides that the situation warrants ongoing medical observation or treatment, that is a transfer of care and should be reported in Section M or N.

Appendix B – Frequently Asked Questions

Where would I report a spontaneous abortion that does not require transfer for medical attention?

Line 13 only, as a client who received services during the reporting year who desired a homebirth at the onset of care.

If I was attending a birth at a home and continued to attend after the mother was transferred to the hospital for delivery, should I report that in Section E?

No, Section E is only for reporting births that occurred *while you were the primary caregiver*. In a transfer of care the receiving caregiver becomes the primary caregiver.

I work with a partner and we do everything together, both are primary at births. Should we take turns reporting or just have one of us report our outcomes and the other just report that no midwife services were performed? It would be nice to report as a practice.

As long as every occurrence is reported and every midwife files a report, it doesn't really matter which of you files the report. Typically clients are divided up with one midwife designated as the reporter/primary for that client. If MANA stats are being submitted, clients should be divided according to who is listed as "midwife 1" in order to use the California Stats page generated at the end of the year.

CALIFORNIA LICENSED MIDWIFE ANNUAL REPORT

DEFINITIONS: (The following definitions govern only the responses provided in this report.)

Antepartum: Same as prenatal; *however*, in formal medical Latin, antepartum is before, intrapartum is during (labor and birth) and postpartum refers to the moment the baby is born (i.e. the laboring woman).

At the Onset of Labor: Midwife has begun to monitor/attend woman in labor (defined as having regular uterine contractions leading to progressive cervical change OR having experienced a ruptured bag of waters).

Collaborative Care/Consultation: This definition captures all clients who were seen by a physician or surgeon during their pregnancy. It includes clients who saw a doctor for a few visits so that insurance would cover their lab work and ultrasound, clients who started care with an OB and transferred to your care, clients who had concurrent ultrasound care with a physician or surgeon during pregnancy as well as clients for whom you or they had an issue that needed medical consult. Nurse Practitioners and Certified Nurse Midwives seen at doctor's offices count as collaborative care providers. It does not include a client who saw a physician for the first time when they transferred out of your care and never returned to your care.

Delivery: Delivery Episode: one mother giving birth, regardless of number of babies delivered, live or dead.

Discovered: The county in which the fetal demise was detected, even if that county is different from the county in which the mother resides or the birth was intended.

Fetal Demise/Stillbirth: A fetal demise/stillbirth applies to the death of a fetus at 20 or more weeks gestation. Death is indicated by the fact that the fetus/stillborn baby does not breathe or show any other evidence of life such as: beating of the heart, pulsation of the umbilical cord, definite movement of voluntary muscles. Heartbeats are to be distinguished from transient cardiac contractions and respirations are to be distinguished from fleeting respiratory efforts or gasps.

Healthcare Practitioner: An individual practitioner (of midwifery or medicine) or a medical facility.

Higher Order Multiples: A single pregnancy resulting in three or more babies.

Infant Death: The death of any infant that occurs within the first six weeks of life.

Information Not Obtainable: An attempt was made to acquire the information, either from the client or the transfer facility, but it was not provided or received.

Intrapartum: Midwife has begun to monitor/attend woman in labor (defined as having regular uterine contractions leading to progressive cervical change OR having experienced a ruptured bag of water).

Live Birth: Birth of one live baby.

Maternal Death: The death of a woman while pregnant or within 6 weeks of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

Morbidity: Birth-related Morbidity = Serious complications for mother or baby relative to pregnancy, childbirth, or the condition of the neonate during the first 6 wks following delivery.

Non-medical Reason: Examples include but are not limited to: client preference, relocation, insurance issues, other inability to pay, lost to care, unknown.

Other: No other option applies.

Out of Hospital Setting: A non-clinical facility, typically a residence.

Postnatal: After the birth *but* refers to the neonate or newborn baby in the first 28 days after birth.

Postpartum: After the infant has been born until 6 weeks later.

Primary Caregiver: Licensed midwife contracted by the client to provide primary care midwifery services during her pregnancy and/or for planned out of hospital delivery. See frequently asked questions for issues surrounding reporting when you share a practice with a partner.

Stillbirth/Fetal Demise: A fetal demise/stillbirth applies to the death of a fetus at 20 or more weeks gestation. Death is indicated by the fact that the fetus/stillborn baby does not breathe or show any other evidence of life such as: beating of the heart, pulsation of the umbilical cord, definite movement of voluntary muscles. Heartbeats are to be distinguished from transient cardiac contractions and respirations are to be distinguished from fleeting respiratory efforts or gasps.

Supervision: Midwife is supervised by a licensed physician or surgeon who will go on record as being the midwife's supervisor for a particular case.

Total: Only include care given in California. Include: all clients who were seen for prenatal care during 2010 but left care for any reason before the baby was born; all clients who had their babies in 2010 whether at home or after transport; all clients you saw prenatally in 2010 who had not had their babies yet at the end of the year. This number should only include clients who entered care intending an out of hospital birth and does not include clients seen for well woman care only, doula clients, or clients who intended a hospital birth but wanted additional prenatal care with a midwife. It does not include clients who were still being seen for postpartum care in 2010 after having babies in 2009.

Transfer of Care: The receiving health care practitioner becomes the primary caregiver.

Unknown: Information is not known to the reporting licensed midwife.

VBAC (Vaginal birth after a previous Cesarean section): Still applies even if the mother-to-be has had a vaginal birth in the interim. For example, a normal birth, then a Cesarean section, a vaginal birth immediately afterwards (VBAC), and then, has another pregnancy and a second VBAC.

AGENDA ITEM 7A

Update on Barriers to Care

Lab Accounts

WILL BE PROVIDED AT THE MEETING

California Government Code

11340.6. Except where the right to petition for adoption of a regulation is restricted by statute to a designated group or where the form of procedure for such a petition is otherwise prescribed by statute, any interested person may petition a state agency requesting the adoption, amendment, or repeal of a regulation as provided in Article 5 (commencing with Section 11346). This petition shall state the following clearly and concisely:

- (a) The substance or nature of the regulation, amendment, or repeal requested.
- (b) The reason for the request.
- (c) Reference to the authority of the state agency to take the action requested.

11340.7. (a) Upon receipt of a petition requesting the adoption, amendment, or repeal of a regulation pursuant to Article 5 (commencing with Section 11346), a state agency shall notify the petitioner in writing of the receipt and shall within 30 days deny the petition indicating why the agency has reached its decision on the merits of the petition in writing or schedule the matter for public hearing in accordance with the notice and hearing requirements of that article.

(b) A state agency may grant or deny the petition in part, and may grant any other relief or take any other action as it may determine to be warranted by the petition and shall notify the petitioner in writing of this action.

(c) Any interested person may request a reconsideration of any part or all of a decision of any agency on any petition submitted. The request shall be submitted in accordance with Section 11340.6 and include the reason or reasons why an agency should reconsider its previous decision no later than 60 days after the date of the decision involved. The agency's reconsideration of any matter relating to a petition shall be subject to subdivision (a).

(d) Any decision of a state agency denying in whole or in part or granting in whole or in part a petition requesting the adoption, amendment, or repeal of a regulation pursuant to Article 5 (commencing with Section 11346) shall be in writing and shall be transmitted to the Office of Administrative Law for publication in the California Regulatory Notice Register at the earliest practicable date. The decision shall identify the agency, the party submitting the petition, the provisions of the California Code of Regulations requested to be affected, reference to authority to take the action requested, the reasons supporting the agency determination, an agency contact person, and the right of interested persons to obtain a copy of the petition from the agency.

**NOMINATIONS TO FILL MIDWIFERY ADVISORY COUNCIL
TERMED POSITIONS**

Applications for Licensed Midwife Position
Diane Holzer
Tanya Khemet
Joyce Moxley Thomas
Carrie Sparrevohn

Applications for Public Member Position
Frank Cuny
Suchada Eickemeyer
Jamie Thayer
Barbara Yaroslavsky



MEDICAL BOARD OF CALIFORNIA

Licensing Program



Midwifery Advisory Council Vacancies

Deadline for Applicant Submissions: March 30, 2011

ATTENTION: ALL INTERESTED PARTIES

The Medical Board of California is seeking applications from interested parties for two positions on the Midwifery Advisory Council (MAC). These three-year term positions are available based upon expiration of two member terms set to expire in 2011. One position is for a Licensed Midwife and the other position is for a public member. The Board is seeking qualified individuals who have demonstrated interest in serving on the MAC. Service is voluntary acceptance of a position on the MAC and requires future time commitments, including attendance at a minimum of four meetings per year.

The MAC was established in 2007 to represent licensees and bring forward the interests of the midwifery community, including physicians, clients, and the public, in a forum to discuss issues and provide advice and recommendations to the Board.

If you are interested in serving on the MAC, please complete a Member Interest Form and **return by fax at (916) 263-2387** OR mail the form no later than March 30, 2011, with your attachments, to:

Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
Attn: Cheryl Thompson / Midwifery Program

If you have any questions concerning the above announcement, please contact Cheryl Thompson at (916) 263-2393 or by e-mail at cheryl.thompson@mbc.ca.gov.

Sincerely,

Curtis J. Worden
Chief of Licensing

MEDICAL BOARD OF CALIFORNIA
Midwifery Program
Midwifery Advisory Council Member Interest Form

Expectations of Membership: The Midwifery Advisory Council (MAC) members volunteer to serve and attend all MAC meetings for a three-year term. Duties and responsibilities include those specified by the Medical Board of California (Board) members, Board staff, or designees. This interest form has been developed to solicit volunteers who will serve on the Midwifery Advisory Council, which is an advisory council that shall make recommendations to the Medical Board of California on matters specified by the Board. The MAC represents the midwifery community and the organizations/associations that represent licensed midwives in the State of California. The Council also includes public member representatives who have an interest in the midwifery community, but are not licensed midwives. To be considered for appointment, please mail or fax your Interest Form by **March 30, 2011** to:

Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
Attention: Cheryl Thompson / Midwifery Program
FAX: (916) 263-2387

If you have any questions please contact Cheryl Thompson at (916) 263-2393.

Name: _____
(Please Print legibly - LAST, First, Middle Initial)

Address: _____
Street Suite/ Apartment # City State Zip Code

Phone: (____) _____ (____) _____ (____) _____
Daytime Evening FAX

E-Mail Address (if applicable): _____ @ _____

Are you a California Licensed Midwife: YES NO (Check only one) License Number: LM # _____

Organization/Association being represented: _____
(If volunteering as a "public member" please insert the word "SELF - PUBLIC Interest")

Position within the Organization/Association: _____
(Board member, executive, or member)

Do you have a prepared Resume or List of Qualifications Available? Yes No
(Please attach Resume or List of Qualifications to this form)

What is your interest in midwifery practice and home births? _____
(Attach additional comments if more space is needed)

(Signature) (Date)

DISCLOSURE: Providing this information is strictly voluntary. The personal information requested on this form is being collected for consideration of appointment as a member of the Midwifery Advisory Council. This information will be reviewed by the Board staff and members of the Board and/or Midwifery Committee. This form will be retained in the files of the Licensing Operations Section. This position is voluntary and will require future time commitments. This form and attachments must be returned no later than March 30, 2011.

Midwifery Advisory Council Reappointment Schedule

Name	Initial Term*	Current Term
Barbara Yaroslavsky	1 Year	2008-2011
Carrie Sparrevohn, L.M.	1 Year	2008-2011
Karen Ehrlich, L.M.	2 Years	2009-2012
Dr. William Frumovitz		2009-2012
Faith Gibson, L.M.	3 Years	2010-2013
Dr. Ruth Haskins	3 Years	2010 -2013
Dr. Guillermo Valenzuela	2 Years	2007-2009/Expired

*All terms after the initial term are for a period of (3) three years.