State of California

State and Consumer Services Agency

MEDICAL BOARD OF CALIFORNIA

MIDWIFERY ADVISORY COUNCIL

December 13, 2011

MEDICAL BOARD OF CALIFORNIA
Licensing Program

MIDWIFERY ADVISORY COUNCIL

MEMBERS OF THE COUNCIL

Karen Ehrlich, L.M., Chair
Faith Gibson, L.M.
Carrie Sparrevohn, L.M.
Barbara Yaroslavsky

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

December 13, 2011

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

AGENDA

12:00 p.m. – 3:00 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 April 7, 2011 Meeting**

4. **Resignation of Council Members** – Ms. Whitney

5. **Midwifery Program Update** – Ms. Robinson

6. **MAC Membership** – Mr. Worden
   A. Discussion and Consideration of Request to Seek Approval to Modify Council Membership
   B. Nomination Process
   C. Discussion of Council Members Terms

7. **Enforcement Report** – Ms. Carrasco

8. **Licensed Midwife Annual Report**
   A. 2010 Annual Report Survey Results
   B. 2011 Annual Report Status Update – Mr. Worden
   C. Discussion of Possible Task Force to Review Licensed Midwife Annual Report Issues – Ms. Ehrlich

9. **Legislative Update** – Ms. Simoes
   A. Update on Legislative Revision to Add Neonatal and Maternal Deaths to Statutory Reporting Requirements (Section 2516 of the Business and Professions Code)
   B. Addition of Retired License Status for Midwives

10. **Discussion and Consideration of Proposed Language to Add a Definition of "Enrolled" to 16 CCR 1379.2 to Clarify Student Status** - Mr. Heppler

11. **Update on Barriers to Care**
   A. Lab Accounts Update– Ms. Robinson
   B. Discussion and Consideration of Proposed Language to Define Appropriate Level of Physician Supervision - Mr. Heppler
   C. Discussion and Consideration of Proposed Language to Provide Authority for Licensed Midwives to Obtain Necessary Supplies and Drugs – Mr. Heppler

12. **Proposed 2012 Meeting Dates**

13. **Election of Officers for Term Beginning with April 2012 Meeting**

14. **Agenda Items for the April 2012 meeting in Sacramento**

15. **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.
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

April 7, 2011

MINUTES

DRAFT

NOTE: The recording of the April 7, 2011 Midwifery Advisory Council meeting was inadvertently destroyed. The minutes of the meeting were created from staff notes and may or may not be complete.

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 12:02 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:
Letitia Robinson, Manager, Licensing Program
Jennifer Simoes, Chief of Legislation
Kurt Heppler, Legal Counsel
Cheryl Thompson, Analyst, Licensing Program
Linda Whitney, Executive Director
Curt Worden, Chief of Licensing

Members of the Audience:
Bruce Ackerman, Midwives Alliance of North America (MANA)
Heather Baker, L.M.,
Claudia Breglia, L.M., California Association of Midwives (CAM)
Jennifer Brown, L.M.
Shannon Smith-Crowley, American College of Obstetricians and Gynecologists (ACOG)
Frank Cuny, California Citizens for Health Freedom (CCHF)
Renee Hanevold, C.N.M.
Jennifer Heystek, L.M.

Diane Holzer, L.M.
Tanya Khemet, L.M.
Constance Rock, L.M., California Association of Midwives
John Toth, M.D., California Citizens for Health Freedom
Veronica Ramirez, California Medical Association

Agenda Item 2 Public Comments on Items Not on the Agenda
No public comment was offered.

Agenda Item 3 Approval of Minutes from the December 9, 2010, Meeting
Ms. Yaroslavsky made a motion to approve the minutes from the December 9, 2010 meeting with minor edits; s/Sparrevohn; motion carried.

Agenda Item 4 Midwifery Program Update
Ms. Thompson reported during the second quarter of FY 2010/11, 11 applications were received and 13 licenses were issued, bringing the total number of licenses issued in FY 10/11 to 23. She noted that the number of licenses issued in the first half of 2010/2011 already exceeded the number issued in all of FY 2009/2010.

At the last MAC meeting, information was requested on the number of licenses that were automatically canceled after five years delinquency. There were no canceled licenses in FY 09/10 and none so far this fiscal year.

As of March 6, 2011, there are 240 renewed and current licensed midwives in CA and 19 in delinquent status.

The Board hosted the NARM exam, which serves as California's licensing exam, at its offices on February 16, 2011. Nineteen individuals sat for the exam. The next exam will be held on August 17, 2011.

Ms. Thompson reported on updates to the midwifery information on the Board's website. The Midwife License Application and LiveScan fingerprinting form are now posted and available for downloading on the midwife home page. A link to the 2010 Licensed Midwife Annual Report (LMAR), along with a helpful user guide developed by the Information Services Branch, is also posted.

At the December 9, 2010 MAC meeting, Claudia Breglia, L.M., CAM President, distributed an updated ACOG Practice Bulletin on VBACs. Staff contacted ACOG and asked for permission to post or link the update on our website, but the request was denied as only members are allowed internet access to Practice Bulletins. However, ACOG may be implementing changes to its website that will allow non-members to view the Bulletins.

At the December 2010 MAC meeting, Ms. Whitney reported the Manual of Model Disciplinary Guidelines that was established for physicians is currently being revised. She requested that any discussion on how these guidelines might apply to midwives be postponed until the revisions were adopted. Staff is currently finalizing the file, which will then be sent to the Department of Consumer Affairs, the State and Consumer Services Agency, and the Department of Finance for

approval before the Guidelines can be filed with the Office of Administrative Law. Once the Guidelines are adopted, staff and legal counsel will contact and work with Ms. Gibson, who volunteered at the last meeting to assist in identifying appropriate sections that could apply to midwives. The findings will then be presented to the Council for consideration after a full review.

Agenda Item 5 Licensed Midwife Annual Report

A. Update on OSHPD / MBC Interagency Agreement

A Memorandum of understanding (MOU) between the Medical Board and OSHPD was reviewed by staff counsel and signed by both OSHPD and MBC. This MOU clarifies the duties and responsibilities of both OSHPD and MBC as it relates to the midwife data collection and reporting to ensure compliance with the Licensed Midwifery Practice Act.

B. Update on Online 2010 Annual Report Survey

OSHPD reported that, as of April 4, 2011, of the 257 midwives expected to complete the LMAR (this includes midwives in delinquent status), 158 midwives have submitted their reports and 99 have not.

There was a glitch that occurred in the LMAR that prevented submissions after the March 30th due date, but this was quickly corrected. A letter will be sent to midwives who have not submitted their reports by April 30, 2011 to notify them of non-compliance and inform them that a hold will be placed on their ability to renew their license until their 2010 report has been submitted. All data submitted prior to the date OSHPD delivers its final report to MBC in July will be included in the aggregate data that will be reported to the Legislature. Based on the comments and questions she has received from midwives completing their reports, Ms. Thompson indicated that the changes that were made in the 2010 LMAR to improve accuracy and internal consistency appear to be working.

A suggestion was made to structure the online reporting mechanism so that the midwife must review the definitions and frequently asked questions sections before beginning the actual reporting of data. It was also suggested that a task force be formed to review the LMAR statistics and reporting process.

C. Update on Legislative Revision to Add Neonatal and Maternal Death to Statutory Reporting requirements

Jennifer Simoes, Chief of Legislation, reported that the requested changes have been included in the omnibus language which will hopefully be amended into the Senate omnibus bill for 2011.

D. Update on MANA Statistics Project for the Mandated Collection of Midwifery Data

At the December 2010 MAC meeting, Bruce Ackerman from the MANA Statistics Project delivered a presentation on MANA's data collection system which allows midwives to report their data in a prospective manner. He reported that MANA Stats is working with the state of Oregon to develop a shortened reporting form that Oregon midwives can use to satisfy their mandated reporting requirements. The MAC members expressed interest in pursuing a similar collaboration with MANA Stats to fulfill California reporting requirements. Any change in the current reporting process will require a full review. In addition, statutory changes will likely be required as the reporting requirements are specified in law. Staff will follow the outcomes of the Oregon collaboration project and this information will be considered in any review.

Agenda Item 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 presented the Collaborative Practice Statement issued by the American College of Obstetricians and Gynecologists (the College) and the American College of Nurse Midwives (ACNM). The College and ACNM have published a new "Joint Statement of Practice Relations" between ob-gyns and certified nurse midwives/certified midwives. The document highlights key principles to facilitate improved communication, working relationships, and seamlessness in the provision of maternity care and other vital women's health services. According to the joint statement, "Ob-gyns and CNMs/CMs are experts in their respective fields of practice and are educated, trained, and licensed, independent providers who may collaborate with each other based on the needs of their patients. Quality of care is enhanced by collegial relationships characterized by mutual respect and trust, as well as professional responsibility and accountability." The announcement was greeted with enthusiasm by the MAC and the midwives present at the meeting.

Agenda Item 7 Update on Barriers to Care

A. Lab Accounts

Letitia Robinson, Licensing Manager, reported she attended a meeting of the Clinical Laboratory Technology Advisory Committee (CLTAC) meeting on January 14, 2011 in order to address the difficulty midwives are experiencing in opening lab accounts. In many instances, midwives are being asked to provide documentation of their supervising physician prior to opening an account. The CLTAC, which is composed of 22 members representing the various interest groups related to clinical laboratories, advises the California Department of Public Health on matters related to clinical laboratories. Although the members were in agreement that, based on the definition of a licensed health care provider in law, licensed midwives are allowed to order lab tests, they cautioned that it is the decision of the independent lab on whether or not to accept a midwife's business.

B. Discussion on Addressing Physician Supervision Via Regulations to Define the Appropriate Level of Supervision

Council members discussed the near impossibility of obtaining physician supervision since malpractice insurance carriers generally prohibit physicians from supervising, consulting with, or backing-up any midwife for homebirth. The requirement for physician supervision in Section 2507 of the Business and Professions Code means that almost all licensed midwives are practicing outside the law. There are a few midwives who are also licensed physician assistants or other licensed health care providers who have physician supervision via their other license, but the vast majority of midwives do not. California is the only state in the nation requiring physician supervision; most states require physician collaboration. The requirement for physician supervision creates difficulties for midwives in the provision of care, including problems in obtaining necessary supplies and tests, transferring care in emergency situations, among others.

Mr. Heppler reported the Board was charged with developing regulations defining the appropriate level of supervision required for the practice of midwifery no later than July 1, 2003. All previous attempts to fulfill this requirement have been unsuccessful, as a consensus could not be reached by the Board and interested parties on what the appropriate level of supervision should be.

Council members, encouraged by ACOG's collaborative practice statement, felt it was timely to make another attempt at regulations.

Dr. Haskins made a motion to ask the Board for permission to pursue regulations to define the appropriate level of supervision; s/Sparrevohn; motion carried.

C. Discussion on Pursuing Regulations in Order to Provide Authority for Licensed Midwives to Obtain Necessary Supplies

Mr. Heppler reported that Section 1379.30 of Title 16 of the California Code of Regulations (CCR) provides that midwifery education programs shall prepare the midwife for management of the normal pregnancy, management of normal labor and delivery in all birth settings, management of the normal postpartum period, newborn care, and family planning and routine gynecological care. This educational preparation includes the administration of intravenous fluids, analgesics, postpartum oxytocics, RhoGAM, vitamin K, eye prophylaxis, diaphragms and cervical caps. While the regulations require preparation for using these substances/drugs and equipment, the law does not specifically authorize the midwife to obtain or administer them. Regulations specifically authorizing midwives to obtain and administer specific formulary drugs, while excluding other legend drugs, may be helpful in addressing the difficulty some midwives are facing in obtaining necessary supplies.

Ms. Sparrevohn made a motion that the MAC request the Board for authorization explore regulations to enhance 16 CCR §1379.30.

D. Status of Petition(s) Filed by Outside Entities to Change Regulations

Ms. Simoes directed members to page 32 of the meeting packet for the sections of California Government Code relating to petitions by outside entities to change existing regulations. She suggested that the California midwifery community, rather than the Medical Board, would be the more appropriate entity to petition the particular regulatory agencies to make changes to existing regulations that they view as restrictive toward midwives, as this is the usual pathway to regulatory change. Ms. Simoes asked if the midwifery community had submitted any petitions, but was told that none had been submitted to date.

Agenda Item 8 MAC Membership

A. Nominations to Fill MAC Termed Positions

Ms. Ehrlich reported that a letter requesting applications for the vacant Council positions was sent to all licensed midwives and interested parties on the MAC's mailing list. Five applications were received for the licensed midwife position and four applications were received for the public member position. Applicants were invited to address the Council. Upon learning of Ms. Sparrevohn's and Ms. Yaroslavsky's desire to continue their service on the MAC, the other applicants present requested that their applications be withdrawn.

1) Licensed Midwife 3-Year Term (expires 2014)

Dr. Haskins nominated Carrie Sparrevohn to be recommended to the Board for reappointment for a three-year term on the Midwifery Advisory Council; s/Yaroslavksy; carried.

2) Public Member 3-Year Term (expires 2014)

Ms. Sparrevohn nominated Ms. Yaroslavsky to be recommended to the Board for reappointment for a three-year term on the Council; s/Haskins; carried.

Ms. Sparrevohn's and Ms. Yaroslavsky's names will be submitted to the Medical Board for consideration at the Board's July 2011 meeting.

B. Discussion and Possible Consideration of Limits of Years/Terms for Council Members
Prior to consideration of possible term limits for MAC members, staff was requested to provide the members with information on member terms and limits for other committee members within the Department of Consumer Affairs. The discussion will be placed on the agenda for the next MAC meeting.

Agenda Item 9 Election of Officers for Term Beginning with August 2011 Meeting
This item was tabled until the August 2011 meeting in Sacramento.

Agenda Item 10 Agenda Items for the August 11, 2011 Meeting in Sacramento
The following items were requested for the next MAC meeting:

- Increasing the size of the MAC by adding a public and licensed midwife member.
- Possible formation of a task force to review the Licensed Midwife Annual Report.
- Report by staff on midwifery enforcement data.
- Review of midwifery schools that do not have an approved challenge mechanism that are allowing students to complete units by examination only (no instruction). Staff was requested to research this practice.
- Review of possible updates or enhancements to the Board's midwifery website.

Agenda Item 11 Adjournment
Upon the conclusion of business, Ms. Ehrlich requested a motion to adjourn; m/Yaroslavsky; s/Sparrevohn; carried.

DRAFT

MIDWIFERY PROGRAM LICENSING STATISTICS

Licensed Midwives	FY 11/12	Q1	Q2	Q3	Q4
Applications Received	9	9			
Applications Pending	6	6			
Licenses Issued	4	4			
Licenses Renewed	24	24			
Licenses Cancelled	0	0			

Licensed Midwives	FY 10/11	Q1	Q2	Q3	Q4
Applications Received	41	12	11	6	12
Applications Pending	2	4	1	2	2
Licenses Issued	40	9	13	5	13
Licenses Renewed	98	30	17	20	31
Licenses Cancelled	3	0	2	0	1

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	3	0	0	2	1

Total Number of Midwives (as of 12/1/11)	
Renewed / Current Status	251
Delinquent Status	31

State of California
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, Ca 95815
www.mbc.ca.gov

Memorandum

Date: December 5, 2011

To: Midwifery Advisory Council Members

From: Curtis Worden, Chief of Licensing

Subject: Composition of Midwifery Advisory Council

At the May 6, 2011 Quarterly Medical Board meeting, Karen Ehrlich, LM, Chair of the Midwifery Advisory Council (MAC), requested that the Board consider modifying the composition of the Council by adding two members (one public member and one licensee, as required by Business and Professions Code §2509) in order to allow representation by a member of the public who has been the recipient of midwifery services. Ms. Ehrlich reported that the midwifery community feels that the voice of parents who have received midwifery care has been missing in discussions and decisions of importance to midwives.

Further, she noted that the addition of another midwife to the MAC would allow representation by a midwife from Southern California, as the licensed midwives currently on the Council are all from Northern California.

At the May 6, 2011 Board meeting, the MAC was authorized to study the issue of adding members to the Council. The Council may make a recommendation to the full Board on the composition of the MAC. The Board will vote whether to adopt the Council's recommendation or make a different determination on the MAC's composition.

History:

The MAC was established by law in 2007 to make recommendations on midwifery matters specified by the Board (B&P §2509). The law specifies that at least one-half of the council members must be California licensed midwives in good standing and one-half members of the public who have an interest in midwifery practice.

Although the size of the Council was not specified in law, staff recommended that the MAC consist of six members (3 licensees and 3 public members). Applications for appointment to the MAC were solicited from all licensed midwives and others who had an interest in home births and the practice of midwifery. Based on the applications received, staff made recommendations for appointments for MAC membership to the Division of Licensing. The recommendations for public members included a current member of the Board, as well as a representative from ACOG and CMA as was suggested by the Midwifery Committee in its November 2, 2006 meeting. During public comment, members of the midwifery community voiced concern with the interpretation of "public member" as the

recommendations included physicians, but excluded non-professional consumers who have received midwifery care. Dr. Fantozzi, chair of the Midwifery Committee and the Division of Licensing, clarified that there was no intent to exclude consumers and other interested parties from attending the publicly held meetings and voicing their concerns. The Division adopted the recommendations made by staff for the size, terms, and membership of the Council at its February 2007 meeting.

Analysis:
There are two options that would allow for the representation on the Council requested by Ms. Ehrlich: (1) appoint two additional members to the MAC (a parent who has used midwifery services and a licensee from Southern California), or (2) retain the current six member MAC composition, but appoint a parent who has used midwifery services to an expiring public member spot and appoint a Southern California licensed midwife to an expiring licensee member spot.

A list of the pros and cons for both options follows.

Option 1: Appoint two additional members to the MAC.

Pros:

- Creating a new public member spot would allow for the appointment of a parent who has received midwifery services and who would bring a different perspective to discussions and vote on decisions. This perspective is not formally represented on the current Council.
- Creating a new public member spot, rather than replacing a current public member spot filled by a CMA or ACOG representative or member of the Medical Board would retain the perspective of these organizations in discussions and their vote on recommendations.
- Creating a new licensee spot would allow for the appointment of a licensed midwife from Southern California, providing geographical balance as the other licensee spots are currently filled by licensed midwives from Northern California.
- The midwifery community would feel they have a voice in the composition of the MAC and greater input into recommendations made to the Board.

Cons:

- Opportunity already exists for parents who have received midwifery services to provide input and share their perspective on Council decisions via public comment. These comments are entered into the public record. Previous audience participation at MAC meetings has been excellent.
- Finding a meeting date and time that works for eight members would be more difficult than finding a date/time for six members.
- The addition of two members would involve fiscal considerations. Based on attendance at four MAC meetings in Sacramento per year, the cost for two additional members would range from $2,000 to $4,000 per year, depending upon where the members live ($2,000 per year if the new licensee member travels from Southern California and $4000 if both the new licensee and public member travel from Southern California).
- In the past, the public and licensee members have not had difficulty in reaching consensus on issues of importance to midwives; hence, the composition of the MAC is not critical to achieving outcomes that are acceptable to the Council.
- In a prior discussion on adding additional members, consensus among existing MAC members was not reached.

- Increasing the size of the MAC to eight members appears excessive given the number of midwife licensees (263). In contrast, there are 15 Board members (currently 9 members due to vacancies) for approximately 125,000 physician licensees.

Option 2: Replace an expiring public member spot with a parent who has received midwifery care and an expiring licensee spot with a midwife from Southern California.

Pros:

- The expiring public member spot could be filled by a parent who has received midwifery services and who would bring a different perspective and voice to discussions and decisions that would be entered into the public record. This perspective is not formally represented on the current Council.
- Even though the vote of the member from CMA, ACOG, or the Board would be lost, there would be opportunity for these organizations to participate in the meetings via public comment; these comments would be entered into the public record.
- The expiring licensee spot could be filled by a licensed midwife from Southern California, providing geographical balance as the other licensee spots are currently filled by licensed midwives from Northern California.
- The midwifery community would feel they have a voice in the composition of the MAC and greater input into recommendations made to the Board.
- With the resignation of two public members, the Council has an opportunity to recommend one of the vacancies be filled by a parent who has received midwifery services and one by a physician who could represent both ACOG and CMA.

Cons:

- Should a parent replace a public member spot currently held by a representative from ACOG or CMA, and should a representative from that organization not attend the meetings to offer public comment, the perspective (and possible support) from these organizations would be lost. These representatives often provide insight into how the physician community would react to proposed regulations or laws pertaining to midwives, suggesting modifications that might make proposals more likely to succeed.
- The public member spot held by a member of the Medical Board provides an important link between the MAC and the Board, providing background and perspective to Board members on midwifery issues. Replacing this individual with a parent representative would mean this link would no longer exist.
- The composition of the Council would no longer reflect the original intentions of the Midwifery Committee, precursor to the MAC, which suggested that the current membership include representatives from ACOG and CMA as the most appropriate.

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Memorandum

Date: December 5, 2011

To: Midwifery Advisory Council Members

From: Curtis Worden, Chief of Licensing

Subject: Nomination Process for Midwifery Council Membership

The MAC was established by law in 2007 to make recommendations on midwifery matters specified by the Board (B&P §2509). Applications for appointment to the MAC were solicited from all licensed midwives and others who had an interest in home births and the practice of midwifery. Based on the applications received, staff made recommendations for appointments for MAC membership to the Division of Licensing. Through February 2011, staff continued to solicit applications and make recommendations to the Board for expiring member positions.

In March 2011, staff once again solicited applications from all California licensed midwives and interested individuals for two expiring Council positions. However, in an effort to allow MAC members a greater voice in the composition of the Council, the applications were presented to the MAC for review. Applicants were invited to address the Council during its publicly held meeting and state their interest in serving on the MAC. A vote was taken on which candidates would be recommended to the Full Board. The Council voted to recommend two existing members for reappointment. Those present at the meeting, which included both licensees and members of the public, echoed their support for this recommendation.

In order to formalize the process, staff is proposing the following Nomination Process:

1. Call for applications – Three months prior to expiration of term, analyst sends letter (and form) requesting applications for vacant positions:
   A. Licensed Midwife - all licensees
   B. Public Member – interested parties (mailing list, ACOG, CMA, and those who have previously applied)
2. Applications are due one month prior to Council meeting. Applications are collected by staff (discipline checks are conducted on licensee applicants) and appropriately redacted for forwarding to MAC members for consideration.
3. Applicants are invited to address the MAC at the appropriate meeting.
4. At the MAC meeting:
   A. Candidates are given the opportunity to address the Council.
   B. Individual members nominate candidates for vote by the MAC.
   C. A vote is taken by show of hands.
   D. The selected candidate's names will be submitted to the Full Board for recommendation for appointment (or reappointment).

5. A Staff Memo is included in Board packet with the MAC's recommendation for appointment; a brief synopsis of the recommended member(s) is included.
6. Full Board votes to accept or reject MAC's recommendation for appointment to Board.

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 <u>strictly voluntary</u>. 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 <u>must be returned no later than March 30, 2011</u>.

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Memorandum

Date: December 5, 2011

To: Midwifery Advisory Council Members

From: Curtis Worden, Chief of Licensing

Subject: Discussion of Term Limits

AT the April 7, 2011 Midwifery Advisory Council (MAC) meeting, an agenda item to discuss possible term limits for Council membership was tabled until staff had the opportunity to research term limit policies for other appointed council or committee positions.

The Midwifery Advisory Council is established by law (Business & Professions Code §2509). Neither the length of terms nor the maximum number of consecutive terms is addressed in law. As a point of reference:

- The Medical Board members are appointed to a position with a four-year term. Business and Professions Code §131 states that Board members may not serve more than two consecutive full terms.
- The Special Faculty Permit Review Committee (SFPRC), which is also established by law, does not have formal term limits. Committee members represent each medical school located in California. The individual schools recommend representatives for membership on the Committee; these representatives serve at the schools' pleasure and by approval of the Board. The Board members that serve on the Committee are subject to the Medical Board's term limits and appointment by the Board president.
- No other committees of the Board are established in law. The members of the Board's various committees serve at the pleasure of the Board president.
- A review of term limits in other states that have a midwifery council or committee similar to that in California is attached.

Midwifery Councils Term Limits in Other States	
Washington	Members serve at the pleasure of the Secretary; may not serve more than 5 years consecutively
Florida	May continue to serve until they have been replaced; no term limit
Virginia	May not serve more than two consecutive 4-year terms; the remainder of any term to which a member is appointed to fill a vacancy shall not constitute a term in determining the member's eligibility for reappointment
New Mexico	3 year terms; no more than two consecutive terms (except for the member from the Division who shall serve at the pleasure of the Division Director and who shall not be limited as to terms
Arkansas	3 year terms; Members may serve two consecutive terms
Texas	6 year terms, with the terms of 3 members expiring on January 31st of each odd numbered year
South Carolina	3 year terms; no mention of term limits
New Jersey	3-year terms; May be reappointed; no mention of term limits.
Minnesota	4 year terms; no term limits; members may serve until their successors are appointed.

Midwifery Advisory Council
Terms of Appointment

Name	Initial Term*	Current Term	Total Years Served To Date
Barbara Yaroslavsky	2007 -2008 (1 Year Term)	2011-2014	4
Carrie Sparrevohn, L.M.	2007-2008 (1 Year Term)	2011-2014	4
Karen Ehrlich, L.M.	2007-2009 (2 Year Term)	2009-2012	4
Faith Gibson, L.M.	2007-2010 (3 Year Term)	2010-2013	4
Public Member (Vacant)	———		
Public Member (Vacant)	———		
Dr. Ruth Haskins	2007-2010 (3 Year Term)	2010 – Resigned November 2011	
Dr. William Frumovitz		2009 – Resigned November 2011	
Dr. Guillermo Valenzuela	2007-2009 (2 Year Term)	Expired	

*Initial appointment terms were staggered to expire after 1, 2, or 3 years. All terms after the initial term are for a period of (3) three years.

Midwifery Program Enforcement Statistics	FY 09/10	FY 10/11 (07/01/10-06/29/11)
Complaints		
Complaints received	7	10
Complaints closed by Complaint Unit	5	8
Investigations		
Cases opened	5	2
Cases closed	3	0
Cases referred to the Attorney General (AG)	1	1
Cases referred for criminal action	1	1
Number of probation violation reports referred to the AG	0	0

AGENDA ITEM 8A

CALIFORNIA LICENSED MIDWIFE ANNUAL REPORT Summary

as of 7/14/2011 8:32:51 AM

SECTION A - Submission Summary

Number of Midwives Expected to Report	**258**
Number Reported	**216**
Number Unreported	**42**
Note: Report Field Numbers 1 through 10 are specific to each midwife report submitted and are not included in this aggregation.	

SECTION B - REPORTING PERIOD

Line No.	Report Year
11	**2010**

SECTION C - SERVICES PROVIDED IN CALIFORNIA - This report should reflect services provided in California only.

Line No.		Total # Yes	Total # 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?	**151**	**65**

SECTION D - CLIENT SERVICES

Line No.		Total #
13	Total number of clients served as primary caregiver during this calendar year.	**3115**
14	Number of clients who left care for a non-medical reason. (DO NOT include these clients in any further categories on this report)	**120**
15	Total number of clients served whose births were still pending on the last day of this reporting year.	**809**
16	Enter the number of clients served who also received collaborative care. **IMPORTANT**: SEE DEFINITION OF COLLABORATIVE CARE!	**1802**
17	Enter the number of clients served under the supervision of a licensed physician and surgeon. **IMPORTANT**: SEE DEFINITION OF SUPERVISION!	**203**

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

(A1) County Code	(A2) County Name	(B) # of Live Births	(C) # of Cases Fetal Demise	(D) # of Infant Deaths	(E) # of Maternal Deaths
01	ALAMEDA	162	0	0	0
02	ALPINE	0	0	0	0
03	AMADOR	0	0	0	0
04	BUTTE	4	0	0	0
05	CALAVERAS	4	0	0	0
06	COLUSA	1	0	0	0
07	CONTRA COSTA	45	0	0	0
08	DEL NORTE	1	0	0	0
09	EL DORADO	19	0	0	0
10	FRESNO	20	0	0	0
11	GLENN	0	0	0	0
12	HUMBOLDT	50	0	0	0
13	IMPERIAL	0	0	0	0
14	INYO	0	0	0	0
15	KERN	37	0	0	0
16	KINGS	1	0	0	0
17	LAKE	7	0	0	0
18	LASSEN	4	0	0	0
19	LOS ANGELES	380	0	0	0
20	MADERA	2	0	0	0
21	MARIN	45	0	0	0
22	MARIPOSA	0	0	0	0
23	MENDOCINO	15	0	0	0
24	MERCED	4	0	0	0
25	MODOC	0	0	0	0
26	MONO	0	0	0	0
27	MONTEREY	2	0	0	0
28	NAPA	24	0	0	0
29	NEVADA	50	1	0	0
30	ORANGE	69	0	0	0
31	PLACER	40	1	0	0
32	PLUMAS	1	0	0	0
33	RIVERSIDE	79	2	0	0
34	SACRAMENTO	53	1	0	0
35	SAN BENITO	1	0	0	0
36	SAN BERNARDINO	60	3	0	0
37	SAN DIEGO	167	1	0	0
38	SAN FRANCISCO	163	1	0	0
39	SAN JOAQUIN	4	0	0	0
40	SAN LUIS OBISPO	36	1	0	0
41	SAN MATEO	29	0	0	0
42	SANTA BARBARA	21	0	0	0
43	SANTA CLARA	44	2	0	0
44	SANTA CRUZ	30	0	0	0
45	SHASTA	51	2	0	0
46	SIERRA	0	0	0	0
47	SISKIYOU	1	0	0	0
48	SOLANO	7	0	0	0
49	SONOMA	47	0	0	0
50	STANISLAUS	7	0	0	0
51	SUTTER	2	0	0	0
52	TEHAMA	2	0	0	0
53	TRINITY	5	0	0	0
54	TULARE	6	0	0	0
55	TUOLUMNE	21	0	0	0
56	VENTURA	97	0	0	0
57	YOLO	14	0	0	0
58	YUBA	5	0	0	0

SECTION F - OUTCOMES OF OUT-OF-HOSPITAL BIRTHS

Line No.		Total #
19	Number of planned out-of-hospital births **at the onset of labor**	**2245**
20	Number of completed births in an out-of-hospital setting	**1840**
21	Breech deliveries	**13**
22	Successful VBAC's	**109**
23	Twins both delivered out-of-hospital	**5**
24	Higher Order Multiples - all delivered out-of-hospital	**0**

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

Line No.	Code	Reason	Total #
25	G1	Medical or mental health conditions *unrelated* to pregnancy	**10**
26	G2	Hypertension developed in pregnancy	**22**
27	G3	Blood coagulation disorders, including phlebitis	**2**
28	G4	Anemia	**3**
29	G5	Persistent vomiting with dehydration	**2**
30	G6	Nutritional & weight loss issues, failure to gain weight	**1**
31	G7	Gestational diabetes	**7**
32	G8	Vaginal bleeding	**3**
33	G9	Suspected or known placental anomalies or implantation abnormalities	**7**
34	G10	Loss of pregnancy (includes spontaneous and elective abortion)	**27**
35	G11	HIV test positive	**0**
36	G12	Suspected intrauterine growth restriction, suspected macrosomia	**8**
37	G12.1	Fetal anomalies	**2**
38	G13	Abnormal amniotic fluid volumes; oligohydramnios or polyhydramnios	**28**
39	G14	Fetal heart irregularities	**4**
40	G15	Non vertex lie at term	**31**
41	G16	Multiple gestation	**11**
42	G17	Clinical judgment of the midwife (where a single other condition above does not apply)	**12**
43	G18	Client request	**37**
44	G19	Other	**23**

SECTION H – ANTEPARTUM TRANSFER OF CARE, URGENT/EMERGENCY

Line No.	Code	Reason	Total #
45	H1	Non pregnancy-related medical condition	**0**
46	H2	Severe or persistent headache, pregnancy-induced hypertension (PIH), or preeclampsia	**8**
47	H3	Isoimmunization, severe anemia, or other blood related issues	**1**
48	H4	Significant infection	**0**
49	H5	Significant vaginal bleeding	**1**
50	H6	Preterm labor or preterm rupture of membranes	**26**
51	H7	Marked decrease in fetal movement, abnormal fetal heart tones, non-reassuring non-stress test (NST)	**8**
52	H8	Fetal demise	**5**
53	H9	Clinical judgment of the midwife (where a single other condition above does not apply)	**0**
54	H10	Other	**0**

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

Line No.	Code	Reason	Total #
55	I1	Persistent hypertension; severe or persistent headache	**6**
56	I2	Active herpes lesion	**1**
57	I3	Abnormal bleeding	**4**
58	I4	Signs of infection	**4**
59	I5	Prolonged rupture of membranes	**31**
60	I6	Lack of progress; maternal exhaustion; dehydration	**179**
61	I7	Thick meconium in the absence of fetal distress	**16**
62	I8	Non-vertex presentation	**18**
63	I9	Unstable lie or mal-position of the vertex	**7**
64	I10	Multiple gestation **(NO BABIES DELIVERED PRIOR TO TRANSFER)**	**1**
65	I11	Clinical judgment of the midwife (where a single other condition above does not apply)	**14**
66	I12	Client request; request for medical methods of pain relief	**50**
67	I13	Other	**2**

SECTION J – INTRAPARTUM TRANSFER OF CARE, URGENT/EMERGENCY

Line No.	Code	Reason	Total #
68	J1	Suspected preeclampsia, eclampsia, seizures	**1**
69	J2	Significant vaginal bleeding; suspected placental abruption; severe abdominal pain inconsistent with normal labor	**4**
70	J3	Suspected uterine rupture	**0**
71	J4	Maternal shock, loss of consciousness	**0**
72	J5	Prolapsed umbilical cord	**1**
73	J6	Non-reassuring fetal heart tones and/or signs or symptoms of fetal distress	**32**
74	J7	Clinical judgment of the midwife (where a single other condition above does not apply)	**13**
75	J8	Other life threatening conditions or symptoms	**2**
76	J9	Multiple gestation **(AT LEAST ONE BABY HAS BEEN DELIVERED OUT-OF-HOSPITAL)**	**0**

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

Line No.	Code	Reason	Total #
77	K1	Adherent or retained placenta without significant bleeding	**7**
78	K2	Repair of laceration beyond level of midwife's expertise	**10**
79	K3	Postpartum depression	**0**
80	K4	Social, emotional or physical conditions outside of scope of practice	**1**
81	K5	Excessive or prolonged bleeding in later postpartum period	**3**
82	K6	Signs of infection	**3**
83	K7	Clinical judgment of the midwife (where a single other condition above does not apply)	**0**
84	K8	Client request	**2**
85	K9	Other	**2**

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

Line No.	Code	Reason	Total #
86	L1	Abnormal or unstable vital signs	**1**
87	L2	Uterine inversion, rupture or prolapse	**0**
88	L3	Uncontrolled hemorrhage	**4**
89	L4	Seizures or unconsciousness, shock	**1**
90	L5	Adherent or retained placenta with significant bleeding	**10**
91	L6	Suspected postpartum psychosis	**1**
92	L7	Signs of significant infection	**0**
93	L8	Clinical judgment of the midwife (where a single other condition above does not apply)	**1**
94	L9	Other	**3**

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

Line No.	Code	Reason	Total #
95	M1	Low birth weight	**1**
96	M2	Congenital anomalies	**9**
97	M2.1	Birth injury	**0**
98	M3	Poor transition to extrauterine life	**6**
99	M4	Insufficient passage of urine or meconium	**0**
100	M5	Parental request	**1**
101	M6	Clinical judgment of the midwife (where a single other condition above does not apply)	**4**
102	M7	Other	**1**

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

Line No.	Code	Reason	Total #
103	N1	Abnormal vital signs or color, poor tone, lethargy, no interest in nursing	**11**
104	N2	Signs or symptoms of infection	**6**
105	N3	Abnormal cry, seizures or loss of consciousness	**2**
106	N4	Significant jaundice at birth or within 30 hours	**1**
107	N5	Evidence of clinically significant prematurity	**0**
108	N6	Congenital anomalies	**2**
109	N6.1	Birth injury	**1**
110	N7	Significant dehydration or depression of fontanelles	**0**
111	N8	Significant cardiac or respiratory issues	**9**
112	N9	Ten minute APGAR score of six (6) or less	**3**
113	N10	Abnormal bulging of fontanelles	**0**
114	N11	Clinical judgment of the midwife (where a single other condition above does not apply)	**2**
115	N12	Other	**0**

SECTION O – BIRTH OUTCOMES AFTER TRANSFER OF CARE

Line No.	Reason	(A) Total # of Vaginal Births		(B) Total # of Caesarean Deliveries	
MOTHER		Code		Code	
116	Without complication	O1	**341**	O8	**190**
117	With serious pregnancy/birth related medical complications resolved by 6 weeks	O2	**10**	O9	**4**
118	With serious pregnancy/birth related medical complications **not** resolved by 6 weeks	O3	**0**	O10	**1**
119	Death of mother	O4	**0**	O11	**0**
120	Unknown	O5	**0**	O12	**0**
121	Information not obtainable	O6	**1**	O13	**0**
122	Other	O7	**0**	O14	**0**
INFANT					
123	Healthy live born infant	O15	**301**	O24	**149**
124	With serious pregnancy/birth related medical complications resolved by 4 weeks	O16	**19**	O25	**4**
125	With serious pregnancy/birth related medical complications **not** resolved by 4 weeks	O17	**2**	O26	**2**
126	Fetal demise diagnosed prior to labor	O18	**4**	O27	**0**
127	Fetal demise diagnosed during labor or at delivery	O19	**6**	O28	**0**
128	Live born infant who subsequently died	O20	**1**	O29	**1**
129	Unknown	O21	**1**	O30	**1**
130	Information not obtainable	O22	**0**	O31	**0**
131	Other	O23	**7**	O32	**2**

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

Line No.	Complication	Out-of-Hospital (A)		After Transfer (B)		Total # from (A) and (B) (C)	
MOTHER		Code		Code		Code	
132	Blood loss	P8	**0**	P15	**0**	P1	**0**
133	Sepsis	P9	**0**	P16	**0**	P2	**0**
134	Eclampsia/toxemia or HELLP syndrome	P10	**0**	P17	**0**	P3	**0**
135	Embolism (pulmonary or amniotic fluid)	P11	**0**	P18	**0**	P4	**0**
136	Unknown	P12	**0**	P19	**0**	P5	**0**
137	Information not obtainable	P13	**0**	P20	**0**	P6	**0**
138	Other	P14	**0**	P21	**0**	P7	**0**
INFANT							
139	Anomaly incompatible with life	P30	**0**	P38	**0**	P22	**0**
140	Infection	P31	**0**	P39	**2**	P23	**2**
141	Meconium aspiration, other respiratory	P32	**0**	P40	**0**	P24	**0**
142	Neurological issues/seizures	P33	**0**	P41	**0**	P25	**0**
143	Other medical issue	P34	**0**	P42	**0**	P26	**0**
144	Unknown	P35	**0**	P43	**0**	P27	**0**
145	Information not obtainable	P36	**0**	P44	**0**	P28	**0**
146	Other	P37	**0**	P45	**0**	P29	**0**

California Licensed Midwife Annual Report
Optional Feedback

Toal Number of Comments: 17 **2010** **As of:** 7/14/2011 8:52:52 AM

Section/Category	Comments/Explanation
M-Other	These 3 babies included 1 with down syndrome, 1 with cleft lip and palate, and 1 with a pulmonary stenosis. All three babies were born lusty and remained at home but were followed during their 6 week post partum period concurrently by myself and specialists.
G-Other	I work for an OB-Gyn Corporation providing prenatal care. I do not presently provide delivery services. The mothers that I provide care for deliver at a local hospital under the care of MD, Ob?Gyn.
G-Other	transfer of care one (1) pt PROM at 35 wks with a breech presentation
O-Infant-Other	Line 124:This baby was transferred urgently but not emergency, was found to have Listeria infection acquired prenatally while mother was traveling outside the United States. He is healthy and well and was discharged from the NICU at 3 weeks of age.
H-Other	I am unsure where to put my 35 week PPROM client. It was not urgent/emergent but of course she did need hospital care and her labor was induced. I would consider that antepartum (mainly because it was not urgent/emergent) or at most intrapartum but not urgent/emergent. I put her in H6 #50 and also G20 #44, but she should probably be in one or the other but not both. I really don't want to call it urgent/emergent.
O-Infant-Other	Just want to clarify that this baby was born at home and brought to hospital after 2 hours of birth for polycythemia.
G-Other	Line 44:This woman transferred in a non-emergent way before labor for suspected rupture of membranes at near-term gestation.
G-Other	This is actually pertaining to Section A. I tried to add my mailing address information, but could not get the fields to accept my data. It says to keep our profile updated, but there is no way to get to the profile page to update any data.
J-Other	J7: client reported she was in labor and requested labor care, but did not express any concern about well-being of baby during phone conversation; upon arrival I was unable to auscultate FHT at first assessment, thus immediate transfer of care to hospital to confirm demise...in addition, this listed as fetal demise discovered under my care in section E
Miscellaneous	One client's military husband had to move out of state with his wife. During their last prenatal, I felt the need for an Ultrasound to be done to ascertain a sudden increase in Fundal Height. They strongly did not want an Ultrasound. Since they were leaving my care anyway I couldn't demand any action from them nor contact their primary physician/Obstetrician since they did not have one. If OBGYN's were REQUIRED to supervise planned OOH clients, more could have been done to ensure a safer outcome
Miscellaneous	I couldn't enter my address. It is

California Licensed Midwife Annual Report
Optional Feedback

Toal Number of Comments: 17 **Reporting Year:** 2010 **As of:** 7/14/2011 8:52:52 AM

Section/Category	Comments/Explanation
G-Other	Patient transported for retained placenta would have been fine but no OB showed up for over 1 1/2 hours, ER doc did not know how to do a manual removal of placenta and pulled on cord for over 1 hour causing excessive bleeding. Once hospital found an OB (misunderstanding who was oncall) patient was taken in for dnc and placenta came right out and bleeding stopped. ER doc almost killed patient!
Miscellaneous	I noticed there was not a place to register out of state births. I cared for 28 clients in the state of Nevada in 2010. I did not record them in the 2010 California stats. Also, I am reporting stats to MANA as well. Is there any way this process could be stream lined to combine the two or just use MANA. The California stat form is to confusing and difficult to use. Would like to see some changes.
G-Other	The licensee information section would not allow me to correct a telephone number error in my profile. The number in error is the #2 phone #:....it should be.
Miscellaneous	Section J - When I arrived at the birth the mother was complete and pushing, thick meconium was noted and no fetal heart tones were found. Baby was born still in the hospital after transfer by ambulance. Cause of death was inconclusive with cause noted as probable cord accident. Section O- This is the same baby noted in Section J
I-Other	This woman had SROM at 34 weeks it was categorized as antenatal transfer by the MANA stats program but seems intrapartum per your definition (ruptured bag I went and evaluated baby, confirming rupture before transfer) This item may need more clarification to avoid confusion. I had to change the number of clients from 8 to 9 that I provided care for when labor started.
G-Other	One baby stopped kicking at 32 weeks - mother informed me 2 days later. Labor was induced in hospital and she delivered a stillborn baby.

CALIFORNIA LICENSED MIDWIFE ANNUAL REPORT

SECTION A - LICENSEE DATA

1a. First:		1b. Middle:		1c. Last:	
2. License Number:					
Numbers 3-10 are voluntary, but will assist OSHPD in contacting you if questions arise relating to your report					
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 OR FETAL DEMISE 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 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 *unrelated* 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 #
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 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 **not** 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 **not** 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

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)	
MOTHER		Code		Code		Code	
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	

MOST COMMON REASONS FOR TRANSFER

	2007	2008	2009	2010
Antepartum Elective	Client request 160	AB: spon & termin 59	Client request 32	Client request 37
	AB: spon & termin 39	Non vertex @ term 48	Non vertex @ term 29	Non vertex @ term 31
	Other 22	Client request 26	AB: spon & termin 27	Fluid: digo /poly 28
	Non vertex @ term 16	Hypertension dev in pg 12	MW clinical judgement 26	AB: spon & termin 27
	Hypertension dev in pg 12	Fluid: digo /poly 12	Hypertension dev in pg 12	Hypertension dev in pg 22
	MW clinical judgement 12	Multiple Gestation 12	Fluid: digo /poly 12	Multiple Gestation 11
			Multiple Gestation 10	MW clinical judgement 10
			Placenta Abreva 8	
Antepartum Urgent / Emergency	Preterm labor or rupture of membranes 16	Preterm labor or rupture of membranes 33	Preterm labor or rupture of membranes 26	Preterm labor or rupture of membranes 26
	Decreased fetal movement / NST 8	Decreased fetal movement / NST 6	Headache / PIH/ Preeclampsia 10	Headache / PIH/ Preeclampsia 8
	Fetal demise 5	Headache / PIH/ Preeclampsia 5	Decreased fetal movement / NST 7	Decreased fetal movement / NST 8
	Non-pg medical condx 3	Fetal demise 5	Fetal demise 6	Fetal demise 5
	Headache / PIH/ Preeclampsia 3			
Intrapartum Elective	Lack of progress/exhaustion/ dehydration 125	Lack of progress/exhaustion/ dehydration 188	Lack of progress/exhaustion/ dehydration 164	Lack of progress/exhaustion/ dehydration 179
	Pt. request pain meds 36	Pt. request pain meds 46	Pt. request pain meds 38	Pt. request pain meds 50
	Prolonged ROM 18	Prolonged ROM 31	Prolonged ROM 23	Prolonged ROM 31
	MW clinical judgement 10	Thick meconium in absence of fetal distress 14	Non-vertex presentation 12	Non-vertex presentation 18
	Thick meconium in absence of fetal distress 9	Non-vertex presentation 11	Mal position 11	Thick meconium in absence of fetal distress 16
	Non-vertex presentation 9	Mal position 10	Thick meconium in absence of fetal distress 10	MW clinical judgement 14
	Mal position 7	Hypertension/ Headache 5	MW clinical judgement 8	Mal position 7
	Hypertension/ Headache 3		S/S Sepsis 4	Hypertension/ Headache 6
			Hypertension/ Headache 3	
Intrapartum Urgent/ Emergency	Fetal Distress 14	Fetal Distress 23	MW clinical judgement 21	Fetal Distress 13
	Vaginal Bleeding/ suspected placental abruption 3	MW clinical judgement 4	Fetal Distress 16	MW clinical judgement 3
	MW clinical judgement 3	Vaginal Bleeding/ suspected placental abruption 2	Vaginal Bleeding/ suspected placental abruption 3	Vaginal Bleeding/ suspected placental abruption 4
	Preeclampsia 2	Cord prolapse 2	PCLX (preeclampsia?) 1	
	Cord prolapse 1			

Postpartum Elective	Laceration beyond MW 14	Laceration beyond MW 24	Laceration beyond MW 14	Laceration beyond MW 10
	Adherent Placenta without significant bleeding 6	Adherent Placenta without significant bleeding 13	Adherent Placenta without significant bleeding 7	Adherent Placenta without significant bleeding 7
	Signs of infection 3	Excessive bleeding in later postpartum 4	Signs of infection 5	Excessive bleeding in later postpartum 3
	Excessive bleeding in later postpartum 2	Client Request 3	Client Request 3	Signs of infection 3
	MW clinical judgement 2	Social, emotional or physical condx outside scope 2	PostPartum depression 2	Client Request 2
		MW clinical judgement 2		
Postpartum Urgent/ Emercency	Adherent Placenta with significant bleeding 9	Adherent Placenta with significant bleeding 10	Adherent Placenta with significant bleeding 8	Adherent Placenta with significant bleeding 10
	Uncontrolled hemorrhage 4	Uncontrolled hemorrhage 7	Uncontrolled hemorrhage 5	Uncontrolled hemorrhage 4
		Abnormal vitals 3	Seizure 3	
Infant Elective	MW clinical judgement 7	Poor transition 6		Congenital anomalies 9
	Poor transition 4	Congenital anomalies 4		Poor transition 6
	Congenital anomalies 3	Low birth weight 1		MW clinical judgement 4
	Low birth weight 2	Other 4		
Infanct Urgent / Emergency	Significant cardiac or respiratory issues 9	Abnormal vital signs, color, tone, lethargy, not nursing 16		Abnormal vital signs, color, tone, lethargy, not nursing 11
	Abnormal vital signs, color, tone, lethargy, not nursing 5	Significant cardiac or respiratory issues 7		Significant cardiac or respiratory issues 9
	Congenital anomolies 4	10 min. Apgar 6 or less 6		Signs of infection 6
	10 min. Apgar 6 or less 3	Significant jaundice w/in 30 hrs 3		10 min. Apgar 6 or less 3
	Significant jaundice w/in 30 hrs 2	Congenital anomolies 2		Abnormal cry, seizures or loss of consciousness 2
	Other 2	MW clinical judgement 3		Congenital anomolies 2

OUTCOMES OF OUT-OF-HOSPITAL BIRTHS

	2007	2008	2009	2010
Planned Out of Hosptial Births at Onset of Labor	1687	2278	1974	2245
Completed Births in Out-of-Hospital Setting	1438	1885	1621	1840
Intrapartum Elective Transfer	226	317	282	333
Intrapartum Urgent/Emergency Transfer	23	33	42	53
Total Intrapartum Transfer	249	350	324	386
Postpartum Elective Transfer	30	51	32	28
Postpartum Urgent/Emergency Transfer	17	29	27	21
Total Postpartum Transfer	47	80	59	49
Newborn Elective Transfer	17	16	21	22
Newborn Urgent/Emergency Transfer	26	29	24	37
Total Newborn Transfer	43	55	45	59
Intrapartum / Postpartum Transfer Rate	17.50%	18.90%	19.40%	19.30%
Newborn Transfer Rate	2.60%	2.40%	2.30%	2.60%
L/S rate	7.7% (130)	8.8% (200)	9.4% (187)	8.7% (195)
Maternal Mortality	0	1	ā transfer - 0 p̄ transer - 1	0
Perinatal/Neonatal mortality				

State of California
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, Ca 95815
www.mbc.ca.gov

Memorandum

Date: December 2, 2011

To: Midwifery Advisory Council Members

From: Curt Worden, Chief of Licensing

Subject: Amendment of Title16 CCR, Section 1379.2 to Add a Definition of "Enrolled"

The Medical Board of California has recently received several inquiries regarding the provisions of Section 2514 of the Business and Professions Code and the practice of midwifery by a student.

Section 2514 provides:

> *" Nothing in this chapter shall be construed to prevent a bona fide student who is enrolled or participating in a midwifery education program or who is enrolled in a program of supervised clinical training from engaging in the practice of midwifery in this state, as part of his or her course of study,* if both of the following conditions are met:
>
> (a) The student is under the supervision of a licensed midwife, who holds a clear and unrestricted license in this state, who is present on the premises at all times client services are provided, and who is practicing pursuant to Section 2507, or a physician and surgeon.
>
> (b) The client is informed of the student's status." (Emphasis added.)

Most of these inquiries involve individuals who may have executed a formal agreement to be supervised by a licensed midwife but are not enrolled in any approved midwifery education program. In some cases, the individual represents that he or she is "studying midwifery on his or her own". In either of these circumstances, the individual is not a bona fide student because he or she is not formally enrolled in a midwifery educational institution. A student must be formally enrolled at an educational institution in order to participate in a program of supervised midwifery clinical training that is offered by that educational institution. A written agreement between a licensed midwife and a "student" does *not* qualify as a "program of supervised clinical training". Accordingly, these types of arrangements are not consistent with the provisions of section 2514.

Staff, with the assistance of legal counsel, has determined that section 1379.2 in Chapter 4 of Division 13, Title 16 California Code of Regulations should be amended to add a definition of "enrolled" in order to clarify the intent of section 2514.

Midwifery Program
Specific Language of Proposed Changes
Draft 11/28/2011

Amend section 1379.2 in Chapter 4 of Division 13, Title 16 Cal.Code Regs. to read as follows:

1379.2. Definitions.
For the purposes of the regulations contained in this chapter and for purposes of Article 24 of Chapter 5 of Division 2 (commencing with section 2505) of the code:

(a) "Accrediting organization approved by the board," as used in section 2515 of the code, means either an accrediting organization that is recognized by the United States Department of Education, Division of Accreditation, or an accrediting organization that is equivalent thereto.

(b) "Board" means the Division of Licensing of the Medical Board of California.

(c) "Code" means the Business and Professions Code.

(d) "Enrolled," as used in Section 2514 of the code, means registered in a formal program of midwifery or supervised clinical training at an academic institution.

~~(d)~~ (e) "Midwifery education program" includes but is not limited to nurse midwifery education programs.

Note: Authority cited: Section 2514.5, Business and Professions Code. Reference: Sections 2505 through 2521, Business and Professions Code.

MEDICAL BOARD OF CALIFORNIA
Licensing Program

RE: Licensed Midwives Laboratory Accounts

There has been some confusion as to whether licensed midwives are independently eligible to open lab accounts. This is to clarify it is the position of the Medical Board of California that licensed midwives, as licensed healing arts practitioners, are independently eligible to open laboratory accounts for medical diagnostic testing within their scope of practice, pursuant to Business and Professions Code §1288, which provides:

> *"Any person conducting or operating a clinical laboratory may accept assignments for tests only from and make reports only to persons licensed under the provisions of law relating to the healing arts or their representatives."*

Clinical Laboratory Technology Advisory Committee
Minutes of the January 14, 2011 Meeting
Meeting held by videoconference from Richmond campus, CDPH,
KP Regional Laboratory, North Hollywood and
Telephone bridge Line

CLTAC members participating

Laurie Armour, Michael Borok, Anthony Butch, Leonard David, Elizabeth Dequinia, Tim Hamill, Jerry Hurst, Lin Kassouni, Donna Kirven, Carmen Maldonado, Peggy O'Toole, Salim Rafidi, Les Revier, Fred Ung, Lori Dean-Yoakum.

Former CLTAC members participating

Victoria Bello, Sam Chafin, Morton Field, Imre Fischer, Robert Footlik, Sol Notrica, Jim Ottosen.

DPH staff participating

Zahwa Amad, Norma Barocio, Grace Byers, Maria DeSousa, Pam Dickfoss, Ron Harkey, Robert Hunter, Nema Lintag, Howard Manipis, Victoria Maxwell, Donna McCallum, Don Miyamoto, Karen Nickel, Bea O'Keefe, Janet Otey, Judy Schlosser, Tom Tempske, Robert Thomas, Clint Venable, Kathy Williams.

Welcome and general announcements

The meeting was called to order by CLTAC Chairperson Tim Hamill. Dr. Hamill apologized for missing the last meeting and thanked Donna Kirven for chairing the meeting in his absence. A roll call was conducted of CLTAC members and Dr. Hamill noted that a quorum was present for the meeting.

Approval of the October 1, 2010 meeting minutes

Dr. Hamill asked participants if there were any additions, deletions, or corrections to the minutes. Dr. Lee Hilborne, Liz Dequinia, Sol Notrica, Imre Fischer and Jim Ottosen said their names were not listed as participants at the last meeting, and these additions were made. For the CLIA update, Donna McCallum said "recents" should be "recerts" and "20 follow ups" should be changed to "20 waived lab follow ups" Maria DeSousa said the reference to 99 approved training programs should be changed to 109. Jim Ottosen asked that the minutes be amended to change his comment that there has never been a response from the CLTAC to "there has never been a response from the CLTAC regarding the new DPH 08-001 regulation package." These changes were made. Salim Rafidi moved that the minutes be approved as amended, Jerry Hurst seconded, and the minutes were approved.

Department news

Pamela Dickfoss was introduced as Acting Deputy Director of the Center for Health Care Quality, replacing Ms. Kathleen Billingsley who took another position in CalPERS. Ms. Dickfoss said that Loriann DeMartini was also working on managing the Center during the transition and Cheryl Munir was Acting Assistant Deputy Director, Administrative Director of Licensing and Certification Field Operations.

Ms. Dickfoss announced that Diana Dooley will replace Kim Belshe as Secretary of Health and Human Services and David Maxwell-Jolly shall be Undersecretary. She said the state budget is still a problem and there is a hiring freeze for all programs. Even though SB 744 authorized new positions for LFS, the program is not allowed to hire at this time because a hiring freeze is in effect.

The new Electronic Online Licensing (EOL) program is still under development after two years. EOL shall standardize licensing for the Department and improve efficiency.

Question: Dr. Borok asked whether furloughs impacted all department staff. Ms. Dickfoss said furloughs were reduced to one day per month but some bargaining units are still negotiating and have three days. Donna McCallum said the furloughs are impacting the CLIA surveyors being able to meet their targets. Dr. Hamill said if Friday furloughs were gone, CLTAC meetings should be moved back to first Fridays.

News and update on LFS

Bea O'Keefe, Chief of LFS, said that LFS had been authorized 35.5 new positions and, despite the hiring freeze, is conducting interviews to be ready to hire when authorized. Currently LFS is interviewing for the Examiner III section chief positions for Richmond and Los Angeles, replacing her position and Bob Thomas' in personnel licensing, plus a new Examiner III in Los Angeles for state inspections. Zahwa Amad is currently Acting Section Chief of Personnel Licensing and Kathy Williams, for Laboratory Licensing. She said it is critical that these positions be filled and also the Program Technician positions, clerical staff performing licensing duties. As soon as possible, LFS would like to interview and hire Examiners I and IIs. There are about 20 candidates on the civil service list.

Ms O'Keefe said work was backlogged in LFS, impacting laboratories and laboratory personnel, especially phlebotomists. The backlog is due to unfilled vacancies and furloughed staff. She is concerned that the contract with Cooperative Personnel services (CPS) is still incomplete and that organization is working without a contract. CPS provides online applications and license verification technology.

SB 744 authorized laboratories to designate inspections by accrediting organizations approved by the department. No agency has been approved yet, but two have expressed interest.

Dr. Horton wants all hospitals linked on an emergency contact system called California Health Alert Network, CAHAN, and that work is underway.

Question: Dr. Hamill asked which two accrediting organizations had applied. Ms. O'Keefe said none had applied yet, but two had inquired about the process.

Question: Dr. Borok asked how many state lab inspectors LFS had now. Ms. Okeefe said LFS had 3 now and approval for 10 more. In addition, the CLIA program had funding for 8 inspectors. She noted that the Bureau of State Audits report several years ago cited the department for not doing inspections and gave a mandate that LFS have adequate staff to do inspections and complaint investigations.

CLTAC member term limits

Dr. Hamill noted that a number of CLTAC members were completing their terms effective the end of last year. He thinks that seven members' terms expired on December 31, 2010 and they may be eligible for renewal of appointment. These persons are: Armour, Butch, Dean-Yoakum, Dequinia, Finson, Swartz and Ung. He asked these persons to apply for reappointment, if willing or eligible, or supply a replacement nomination. He asked them to contact Bea O'Keefe. Dr. Hamill said it appears that the following persons' terms expire at the end of 2011: Borok, Hamill, Kassouni, Kirven, Maldonado, O'Toole, Rafidi, Revier, Terry and York. Some of

these members may be completing their second term and be ineligible for renewal of appointment.

Question: Jim Ottosen said the CLTAC bylaws state that the CLTAC Chairman is elected in December and starts serving in June, so the election of Tim Hamill at the last meeting is invalid since he cannot serve beyond this year. Dr. Hamill agreed that a new chairperson should be elected and asked that the nominations be opened. Les Revier nominated Lori Dean-Yoakum, seconded by Donna Kirven. Ms. Dean-Yoakum agreed to stand for the election. Dr. Borok asked how a person from southern California could serve as chair. Would they have to fly to Richmond each time? Bea O'Keefe said the LFS Chief could go to North Hollywood and the CLTAC chair in southern California could come north, but the two individuals would have to be at the same location. Dr. Hamill opened the nominations again. Laurie Armour nominated Jerry Hurst, seconded by Salim Rafidi. Mr. Hurst agreed to the nomination. Hearing no further nominations, Dr. Hamill closed the nominations and a vote of the CLTAC was held. Lori Dean-Yoakum was elected new chair of CLTAC, for one year staring July 2011.

Subcommittee Selection for Personnel Regulations

Dr. Hamill said there had been a request that the CLTAC form a special subcommittee to have input on the personnel regulations, DPH-08-001. He solicited persons who would serve on the subcommittee and a number of persons volunteered, including Hilborne, Rafidi, Ottosen, Revier, Dean-Yoakum, OToole, Borok, Footlik, Armour, Hurst, Maldonado, Joseph Musallam, Michele So, Field, Kassouni, Dequinia, Becky Rosser, Mora Williams, Hamill.

Question: Salim Rafidi said there were only 15 days to meet, this was a big committee and questioned how it would work. Jerry Hurst said the group should be limited to 10 persons, 5 CLTAC and 5 public members. Les Revier suggested 11 persons, 7 CLTAC and 4 public. Dr. Field said the CLIA crosswalk committee has many members but not all participate, so many members are needed. Bea O'Keefe said she was not sure what role LFS should play and would research that. Michael Aiden said the public should be represented. Dr. Borok said everyone should be allowed. Liz Dequinia asked how a committee would be chosen. Dr. Field made a motion that a physician be allowed and Bea O'Keefe said the motion was out of order since Dr. Field is not a member of the committee. Dr. Borok repeated the motion and it failed to pass. Lin Kassouni made a motion that anyone could participate in the subcommittee, seconded by Les Revier and Michael Borok, motion passed with 19 persons identified as interested in participating in the subcommittee.

Salim Rafidi volunteered to chair the subcommittee on DPH-08-001 review. He said he would organize it, generate a report and report back to the CLTAC. Bea O'Keefe said a special meeting of the CLTAC may be necessary to review and approve the report. Mr. Rafidi was concerned that this could be done in 15 days and suggested some dates for meetings. Dr. Hamill noted that any meeting of the subcommittee would be open to the public.

Midwife ordering laboratory tests

Leticia Robinson of the Midwifery Board said there has been a problem with laboratories not accepting test requests from licensed midwives. These persons are licensed under the healing arts through the Medical Board of California and work

under the supervision of a licensed physician. They are authorized to open accounts with a laboratory, collect samples, and order tests limited to the birthing process. The issue is that midwifes have had difficulty in establishing accounts with laboratories. Bea O'Keefe stated there is nothing in laboratory law at Business and Professions Code 1288 that would prohibit midwifes from ordering tests.
Question: Tim Hammil asked if they are required to be nurses.
Ms. Robinson answered that midwifes are not required to be licensed nurses.
Question: Dr. Borak asked if they work independent of physicians.
Ms. Robinson said that the Medical Practice Act requires them to be under a physician.
Question: Tim Hammil asked if the physician is the authorizing person or can midwifes order tests.
Ms. Robinson said that midwifes can order tests.
Question: Do they have limitations on tests they can order and is there a list of tests they can order. Jim Ottosen asked if ordering was limited to prenatal and birthing process. Ms. Robinson said there was not a specific list. Les Revier asked whether the lab needed an informed consent from the patient to protect liability. The answer was, no. Testing does not require informed consent as it is part of the pre- and postnatal care. Dora Goto stated that persons can self-order certain tests and that the lab can decide whether they want to accept the order. She then asked whether lab tests ordered by a midwife are reimbursable by insurance and Ms. Robinson said this was a problem sometimes. Jerry Hurst asked if there was a problem with Medicare and Medicaid payments. Leticia stated that both are a problem. Dr. Fields stated that labs can decide whether they want to accept an account. Dr. Field said that once a lab sets up an account with a client, they usually accept all tests.
Question: In emergency care, who would be responsible for ordering blood tests.
Ms. Robinson answered that the patient would be transferred to a hospital.
Bea O'Keefe stated that a laboratory has the right as to whether to accept a requisition from an authorized person.
Ms. Robinson announced that there would be an Advisory Committee meeting on physician responsibility in the supervision of Affiliated Health Care Professionals to be held January 27th in San Francisco.

Facility licensing section

Kathy Williams, Acting Section Chief of Facility Licensing, said LFS is having problems processing fees and has a 30-60 day backlog. Laboratories that pay by the expiration date have a 60 day grace period in which they can continue operating without licensure and without paying a delinquent fee. With the backlog, some laboratories are getting delinquency notices when they paid on time, and this is causing consternation. Ms Williams said LFS is hearing from out-of-state mobile wellness clinics who want to hire middlemen phlebotomists to process samples. LFS is getting applications from franchise labs, as Doctor's Express, which want to do waived testing. Also, she is hearing from "telehelp-telelab" facilities doing testing at one site and reporting offsite.

Question: Tom Tempske said rural clinics in Africa were offering malaria testing. Dora Goto said the PPMP application for state registration is missing director attestation forms. Kathy Williams said these may be eliminated.

Personnel licensing section

Zahwa Amad, Acting Section Chief for Personnel Licensing, thanked her staff for

their hard work while short handed and hampered with furloughs. She said that there have been a flood of renewals, especially from phlebotomists. Renewal notices are sent out 90 days prior to expiration and if they are not returned immediately, they are caught in the backlog. There is no grace period for phlebotomists and they are often suspended from work. LFS received 3,000 renewals at the end of the year. Dr. Amad urged persons to send in their changes of address so renewals are not lost. She said LFS was implementing a new process for California CLS trainees, where the program director gives advance notice of completion of training so licensure can be expedited.

Question: Grace Byers told participants to tell their HR departments about the 90 day grace period for CLS'. Robert Thomas said an oral exam was given October 10, 2010 and is scheduled for February 11, 2011. Dr. Borok asked when online renewals would be available. Ms Williams said the EOL should be ready by 2014. A participant asked if the turn around time for specialists is the same as for CLS'. Dr. Amad said the backlog is currently about 3 months.

Milk banking and tissue banks in California

Because of time constraints, this presentation by Jan Otey was postponed until the next meeting.

Complaints received by LFS

Tom Tempske, LFS Complaint Program Manager, reported on complaints, saying fourth quarter 2010, LFS received 63 complaints. LFS received a total of 197 complaints in 2010 compared with 228 in 2009. Of the complaints received in 2010, 106 have been closed and 39 are outside the purview of LFS. Most of the complaints deal with billing, reporting and phlebotomy. Complaints come in by letter or email. Many people are now using the complaint website sponsored by the department (lab.complaints@cdph.ca.gov).

CLIA update

Donna McCallum, Section Chief of the CLIA program, said the federal calendar starts October 1 and ends on September 30 of each year. The first quarter 2010, LFS conducted 26 initial surveys, 134 recertification surveys, 2 follow ups, 5 validation and 5 PT sanctions, plus 46 waived lab paper reviews.

Question: Someone asked about the CLIA requirement for physician signature on test requests. The test request must include physician name, tests and patient information. Dr. Hamill said the ruling on the issue is expected in March 2011 with a 3 month phase in. Dr. Field asked whether the lab or the ordering physician should be responsible for assuring a signature is provided. The signature is necessary for reimbursement. Dr. Hamill said an audit of the lab is easier than going to physician offices. Dr, Borok asked about physician office labs, whether a signature is needed.

Personalized health information technology

Kathryn Lowell was unable to attend the meeting so the presentation shall be given at a later meeting.

Meeting schedule for 2011

Dr. Hamill asked that the meeting dates be selected for 2011, assuring that Richmond and Kaiser Permanente North Hollywood facilities were available.

The dates selected with March 4, 2011, June 3, 2011, September 2 or 9, 2011 and December 11, 2011.

Open discussion
Salim Rafidi asked to continue discussion on when the DPH-08-001 review subcommittee could meet. He asked about how to contact the public so they would know about the meeting as required. He asked whether videoconference facilities in Richmond and North Hollywood would be available and what kind of support LFS could provide. Several provisional meeting dates were selected. Mr. Rafidi said he would work to get the subcommittee going.

New business
Dr. Hamill asked if there were any new business and there was none.

Future agenda items
CLTAC member (not identified) asked how LFS was responding to the BSA audit for providing improved service to its laboratory clients. Other future agenda items included the status of the CLIA crosswalk subcommittee, milk banking, personalized healthcare information technology. Jim Ottosen asked how the Office of Regulations views the CLTAC and why it was not involved at the beginning of regulation development. Jerry Hurst made a motion that a formal clarification by the Office of Legal Services and the Office of Regulations on the role of CLTAC be given. This was seconded by Donna Kirven and Salim Rafidi, and the motion was unanimously approved.

Dr. Hamill made a motion that the meeting of the CLTAC be adjourned; the motion was seconded and approved. The meeting was closed at 12:20 PM.

Medical Board of California
Physician Supervision of Midwives
Specific Language of Proposed Changes
Draft—11-29-11

Adopt section 1379.23 in Article 3.5 of Chapter 4 of Division 13, Title 16 Cal.Code Regs. to read as follows:

1379.23. Physician Supervision Requirement.

(a) The requirement for physician supervision contained in Section 2507 of the Code is deemed to have been met if the licensed midwife has established an informal, collaborative relationship with at least one physician who meets the requirements of section 1379.22 and who agrees to provide guidance and instructions regarding the care of pregnant women and/or newborns during a normal pregnancy and to provide emergency advice should complications develop.

(b) A physician and surgeon shall not be deemed to have established a business relationship or relationship of agency, employment, partnership, or joint venture with the licensed midwife solely by providing consultation to or accepting a referral from the licensed midwife.

NOTE; Authority cited: Sections 2018 and 2507(f), Business and Professions Code. Reference: Section 2507, Business and Professions Code.

Medical Board of California
Midwifery Program
Specific Language of Proposed Changes
Draft—11-29-2011

Adopt new section 1379.24 in Chapter 4 of Division 13, Title 16 Cal.Code Regs. to read as follows:

1379.24. Practice of Midwifery.

A licensed midwife shall have the authority, limited to the practice of midwifery, to obtain and administer drugs, immunizing agents, diagnostic tests and devices, and to order laboratory tests. This authority includes, but is not limited to, obtaining and administering intravenous fluids, analgesics, postpartum oxytocics, RhoGAM, local anesthesia, paraceravical blocks, pudendal blocks, local infiltration, vitamin K, eye prophylaxis, diaphragms and cervical caps.

NOTE: Authority cited: Section 2018, Business and Professions Code.
Reference: Section 2507, Business and Professions Code.

PROPOSED MIDWIFERY ADVISORY COUNCIL MEETING DATES FOR 2012

April 5, 2012

August 23, 2012

December 6, 2012