

State of California
State and Consumer Services Agency

MEDICAL BOARD OF CALIFORNIA



MIDWIFERY ADVISORY COUNCIL

August 8, 2013



**MEDICAL BOARD OF CALIFORNIA
Licensing Program**



**MIDWIFERY ADVISORY
COUNCIL**

August 8, 2013

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

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

While the Board intends to webcast this meeting, it may not be possible to webcast the entire open meeting due to limitations on resources.

AGENDA

1:00 p.m. – 4:00 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 the Midwifery Advisory Council Meeting Minutes
 - A. August 30, 2012
 - B. March 14, 2013
4. Report from the Midwifery Advisory Council Chairperson – Ms. Sparrevohn
5. Selection of a New Midwifery Advisory Council Member
6. Sunset Review Report Update – Ms. Lowe
7. Update and Discussion on Assembly Bill 1308 – Practice of Midwifery
8. Program Update – Ms. Lowe
 - A. Licensing Statistics
 - B. 2012 Licensed Midwife Annual Report
 - C. Enforcement Statistics Report

9. Agenda Items for the December 5, 2013 Midwifery Advisory Council Meeting - Sacramento

10. Adjournment

The mission of the Medical Board of California is to protect health care consumers through the proper licensing and regulation of physicians and surgeons and certain allied health care 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 Lisa Toof at (916) 263-2389 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) 263-2389.





MEDICAL BOARD OF CALIFORNIA
Licensing Operations



Midwifery Advisory Council

Hearing Room
2005 Evergreen Street
Sacramento, CA 95815

August 30, 2012
MINUTES

Agenda Item 1 Call to Order/Roll Call

The Midwifery Advisory Council (MAC) of the Medical Board of California (Board) was called to order by Chair Carrie Sparrevohn at 1:05 p.m. A quorum was present and notice had been sent to interested parties.

Members Present:

Carrie Sparrevohn, L.M., Chair
James Byrne, M.D.
Karen Ehrlich, L.M.
Faith Gibson, L.M.
Monique Webster
Barbara Yaroslavsky

Staff Present:

Diane Dobbs, Department of Consumer Affairs, Legal Counsel
Kurt Heppler, Staff Counsel
Natalie Lowe, Licensing Manager
Susan Morrish, Licensing Analyst
Anthony Salgado, Licensing Manager
Kathryn Taylor, Licensing Manager
Linda Whitney, Executive Director
Curt Worden, Chief of Licensing

Members of the Audience:

Jen Brown
Brooke Casey
Yvonne Choong, CMA
Laurie Gregg, M.D., ACOG
Joselyn Grole, CAM
Deanna Jesus, CAM
Tosi Marceline, LM
Diane Moher, MANA
Debra Newberry Puterbaugh, CAM
Constance Rock, LM, CAM
Shannon Smith-Crowley

Linda Walsh, CNM

(The above list identifies attendees who signed the meeting sign-in sheet.)

Agenda Item 2 Public Comment on Items not on the Agenda
No public comment was provided.

Agenda Item 3 Approval of the Minutes from the March 29, 2012 Meeting
Ms. Sparrevohn made a motion to accept the minutes from the March 29, 2012 meeting; s/Yaroslavsky; motion carried.

Agenda Item 4: Consideration of Revised Regulations; Possible Recommendation to Full Board

A. 1379.23 - Physician Supervision Requirement

Ms. Lowe provided information on the recommendations for two proposed midwifery regulations:

- 1379.23 - Physician Supervision Requirement
- 1379.24 - Practice of Midwifery; Drugs and Devices

The revised proposals were based on recommendations made by members of the public and the midwifery community during the March 29, 2012 "Interested Parties" workshop.

The Physician Supervision Requirement was the first regulation discussed. Ms. Lowe identified Business and Professions Code 2507 (f) which requires the Board to adopt regulations defining the appropriate standard of care and level of supervision required in the practice of midwifery; pointing out that since 2006, three regulatory attempts for a consensus on the supervision requirement have failed.

The proposed section 1379.23 of the California Code of Regulations sets forth a collaborative approach to the issue of physician supervision provided that the licensee establishes a collaborative relationship with a physician who has agreed to provide guidance and instruction within specific circumstances. The proposed regulation also ensures that a business relationship is not created between the physician and licensed midwife solely by consulting with or accepting a referral from the licensed midwife. Ms. Lowe requested that the following language be approved by the MAC and recommended to the Full Board to set for hearing:

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 a collaborative relationship with one or more physicians, who meet the requirements of section 1379.22, for the purpose of providing guidance and instructions regarding the care of women and/or newborns or consulting with the licensed midwife after the care of a patient has been transferred to the physician.

(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 a licensed midwife solely by consulting with 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.

Ms. Yaroslavsky asked for a motion to approve the language to present to the Full Board; s/Gibson.

Ms. Sparrevohn asked for committee input on the issue. Ms. Ehrlich had concerns that the proposed language does not provide a definition for physician collaboration when risk factors are an issue. Ms. Ehrlich asked Ms. Dobbs if the absence of a specific definition would leave midwives unable to function independently during cases of normalcy.

Ms. Dobbs answered that, in general, very minute details should be left out of regulations because such details make it difficult to accomplish the main goals.

Dr. Byrne expressed concern that the current language does not define low risk versus high risk and still leaves a requirement for a supervisory relationship. He believes the language is simply changing the relationship from supervisory to collaborative and does not provide for a truly independent practice. Ms. Dobbs disagreed stating that she does not see the proposed regulation language changing the scope of practice for midwives. Ms. Yaroslavsky also had concern that it would be better to leave the assumptions ambiguous, otherwise the regulation would have limitations in what the Council was trying to achieve. Ms. Sparrevohn agreed that the language was specific enough and that it was not going to change how licensed midwives practiced in California.

Dr. Byrne stated that from a risk management standpoint, he has seen plaintiff's attorneys try to draw a relationship where even a midwife's phone call to a doctor can bring both parties into a lawsuit regardless of status. He mentioned in statutes for certified nurse midwives (CNM), the term "supervision" is clear in what it means.

Ms. Sparrevohn stated that we won't know if this will meet the intended goal until we put it into practice.

Ms. Sparrevohn stated that, because no one from the insurance industry attended the Interested Parties meeting, input from them was not provided on the proposed regulation language.

Ms. Dobbs asked Council Members to keep in mind that the regulatory language was a suggestion, and she stated interested parties could participate in the regulatory process and make recommendations for any language that is not clear. Ms. Yaroslavsky asked Ms. Dobbs if she was suggesting the Council should move forward with the recommendation and see what takes place during the Public Hearings. Ms. Dobbs responded affirmatively, stating that there would be plenty of opportunity to fine tune the language.

Ms. Sparrevohn asked if there were any additional comments from Council members. Seeing none, she asked for public comment.

Mr. Cuny identified himself as the Director of California Citizens for Health Freedom. He

mentioned his organization has followed the issue of physician supervision for about 15 years, and he claims physician supervision has been a problem for the public, midwives, doctors, and the Board and needs to be dealt with. He suggested the Board should sponsor legislation that might resolve the existing problems for all involved parties. If it is sponsored by the Medical Board, the chances of it passing are greatly increased.

Yvonne Choong with the California Medical Association (CMA) expressed concern that the proposed regulation fails to define and establish what a collaborative relationship is. Ms. Choong believes more definition is needed by identifying what is low risk and what is high risk for physicians and insurance carriers. For insurance carriers, more detail will be better.

Ms. Choong asked for clarification in the following areas: when care has been transferred to the physician; and, what informed consent is provided to the patient that addresses the nature of the relationship between physician and licensed midwife.

Ms. Sparrevhohn invited Dr. Gregg from the American College of Obstetricians and Gynecologists (ACOG) to speak. Dr. Gregg introduced Ms. Smith-Crowley as a lobbyist for ACOG and herself as Chairperson for District 9 in California. Dr. Gregg expressed concern that the word "collaboration" was too vague. She attended the March 29, 2012 Interested Parties meeting and mentioned that former MAC member, Dr. Haskins, provided written comments to the Board on the Physician Supervision regulation. She felt the staff tried to incorporate what was suggested in the proposed regulation, but she believes the language could be better articulated. She suggested working on the language during the current meeting and to send the proposal forward to the Board.

Dr. Gregg identified three issues that she would like defined/incorporated into the regulation: improve informed consent; if physician supervision is removed, she recommends home births are limited to low risk pregnancies as defined by the World Health Organization; and, to change "collaboration" to "midwifery directed physician consultation."

She believes the client needs to know: the training and education of the licensed midwife; the midwife is not a nurse midwife or a physician; there is no physician supervision; a Transfer Plan is in place and it outlines what the transfer plan consists of; whether or not the midwife carries liability insurance; and, additional information on the grievance process.

Dr. Gregg stated that based on home births that work well in other states, it is safer for the consumer if home births are limited to low risk births. She offered the following suggestions pertaining to transporting the mother to the hospital when necessary: the midwife engages the physician when she feels it is needed; physician consultation is done on a face-to-face basis and continues with the California standard of non-vicarious liability; the physicians are not held responsible for situations that occur at the home and outside of their presence; and, the physician assumes responsibility once the client/patient is transferred to the hospital and engages with the physician.

Dr. Gregg believes the wording of the proposed regulation does not reduce the liability concerns for doctors but could potentially make it worse. Ms. Smith-Crowley interjected by specifying that there are two separate issues, ACOG issues and liability issues.

From the standpoint of ACOG and the liability insurance carriers, Ms. Smith-Crowley recommended to stay within the standard of care by having a consultative relationship. She has not found anything that says a physician cannot supervise or consult, collaborate or have back up for a licensed midwife who provides care at a licensed birth center.

Ms. Smith-Crowley does not see a solution to the issue of liability coverage, nor does Dr. Gregg despite her national committee work. Her reading of studies indicate that the best care comes with a home birth that is delivered within an integrated system, but currently, that is not possible. She does not believe just removing physician supervision from the regulation is going to be in the best interest of the woman or baby. She suggests incorporating Dr. Gregg's recommendations for now and then work on revising the legislation later.

Ms. Yaroslavsky asked Council Members, "Does having the additional information within the specific language of the regulation resolve the issue?" Ms. Ehrlich stated that it would be redundant because midwives are required to have a Transfer Plan and are required to inform the client whether or not they carry malpractice insurance. She suggested a legislative fix should occur if the regulation needs strengthening.

Ms. Yaroslavsky countered by stating if the information was already in law or statute, it would not be redundant to have everything identified in one regulation. Ms. Sparrevohn suggested the language should combine all the requirements into one informed consent that references the Standard of Care for California Licensed Midwives.

Dr. Gregg stated that such a refinement certainly wouldn't hurt, and agreed that the additional language would better define the collaborative relationship between physician and licensed midwife. She suggested taking wording from national documentation, and she referenced a collaborative statement that is currently in place with certified nurse midwives who have standardized training. Due to the differences in how licensed midwives are trained, doctors are somewhat cautious about involving themselves. Physician protocol is to consult or seek assistance with a higher specialist when medical issues are outside his/her scope. Physicians may touch base immediately with a specialist by phone but then would send the patient to have a face-to-face consult to get a better impression of what is going on. She recommended a midwife-directed consultative process where the physician and the client/patient see each other face-to-face and then, if necessary, when the patient is transferred.

Dr. Byrne felt that the consultation suggestions integrated with the language from the World Health Organization criteria would be very helpful. Regarding current regulations, he said there are midwives who want to practice clinically in a safe manner but are having a hard time finding physician supervisors. Physicians often are not willing to be supervisors because they do not want to be involved with clinical problems that could have been avoided with earlier contact or be drawn into litigation issues.

Dr. Byrne suggested that the regulatory changes should not be a one-sided relationship where midwives are in agreement and the regulations would not change the paradigm for the doctors. Dr. Gregg agreed and stated that, unfortunately, the liability insurers wouldn't sign on in this case.

Ms. Ehrlich asked Dr. Gregg if midwifery-directed consultation would involve every client under the care of a midwife. Dr. Gregg responded no. Dr. Gregg indicated that the requirements vary from state to state. Dr. Gregg believes that if a woman chooses home birth, the hope would be that it is done with adequate education and informed consent and that the physicians are available should the midwife need them.

Ms. Ehrlich reiterated that "informed consent" was currently included in the laws and regulations. She pointed out that, over the years, the concept of "moderate risk" disappeared from maternity care conversations about risk, and that the language identifying "moderate risk" was removed. Ms. Ehrlich stated that pregnancies are not just low risk and high risk; she argued that women in the moderate risk category have a right to determine their own care in the setting of their choice, and that we don't want to push women into an unassisted homebirth; that they deserve competent, vigilant care in the setting of their choice. Dr. Gregg mentioned that home births for multiples, breeches, and vaginal births after cesarean are legal in California, although ACOG continues to disagree with that.

Ms. Ehrlich stated that full informed consent is the centerpiece for midwifery. Ms. Sparrevohn added that the Standards of Care for Licensed Midwives were passed well after midwives knew they did not have physician supervision. The proposed regulation can't change the law about supervision, but is trying to change the way supervision is defined.

Ms. Gibson stated that at one time a document had been produced by the Board that listed all of the possibilities for defining supervision, including that a midwife calls a doctor when there was a problem to consult about. She added that the definition of supervision that results in vicarious liability is not the bottom line definition, despite malpractice carriers considering that to be so. She asked Dr. Gregg to provide a definition for physician supervision and to define language used within states that do not require physician supervision.

Dr. Gregg stated that the word "supervision" was less than ideal because she thought what was being discussed was not truly supervision and did not describe the situation. She stated that a minority of states have a mandate where a client choosing home birth must consult with a doctor. She offered to provide language utilized in other states, but did not currently have the information. She added that the practice of midwifery has evolved in the last 20 years and other entities may have been involved when physician supervision was placed in the law. Dr. Byrne said that it is a challenge to compare all states because some states do not allow licensed midwifery.

Ms. Webster expressed interest in removing barriers to care and addressing liability issues. She asked if there had been feedback from the insurance companies. Ms. Ehrlich responded that they had been invited to the Interested Parties Workshop but did not attend. Ms. Sparrevohn stated that they will show up when the issue gets set for hearing.

Ms. Sparrevohn invited Ms. Holzer to speak on this topic. Ms. Holzer introduced herself as a midwife and stated that she liked the language in the current draft, even though it wasn't perfect. In her opinion, it reflected what was actually happening with midwives who have collaborative relationships with physicians. She stated that there were physicians across California who do collaborate with midwives but are not able to supervise. She was in agreement with the suggestions Dr. Gregg recommended, but did not see how defining the word "collaborate" would

work. She asked how many midwives have collaboration, based on the Office of Statewide Planning and Development, (OSHPD) statistics. Ms. Ehrlich provided the following data:

- Clients served while the licensed midwife had supervision in 2011: 6.5%
- Clients who received collaborative care: 58.2%

Ms. Holzer pointed out the statistics reflect more than half of the midwives received collaborative care, and she stated that defining collaboration would backfire on the midwives. Ms. Holzer was interested in knowing what the physicians collaborating with midwives thought about the regulation and asked if ACOG knew whether the physicians wanted a more defined relationship, or if they believed that would make it worse.

Dr. Byrne stated that a lot of the work he performs is directed at improving health care systems and individual care for individual women. He pointed out that the self-reported "collaboration" at 60% is great, but he questioned whether the persons identified as the "collaborators" knew they were the collaborator. Midwives responded that they did not necessarily identify themselves as collaborators.

Ms. Grote identified herself as a licensed midwife in Santa Cruz County and stated that most midwives in California collaborate with a doctor who is on call, "in house" at the time of need. She claims many midwives have informal relationships with doctors they can call for non-emergent consultation.

Ms. Grote questioned what would happen if a midwife could not find a doctor in her community to collaborate with. She questioned, "What would happen if a doctor did not want to provide consultation for the 20 midwives in his/her city?" Ms. Sparrevohn mentioned that the hope of implementing the regulation would be to provide a more fluid process. If it didn't, the next step would be to amend the law.

Ms. Grote asked if the regulation would provide further definition in identifying the consulting doctor and what the consultation was about via the charting process. Ms. Sparrevohn explained that the regulation did not specify how a midwife should document the information but she said the consultation process may be negotiated differently between the midwife and each physician.

Ms. Grote asked if there was any value in having a regulatory stipulation for the midwife if she was unable to find a collaborating doctor. Ms. Sparrevohn acknowledged that there are places where there are no collaborating physicians, but she said it is unclear whether requiring a collaborative relationship would make the situation easier or harder until it was tried.

Ms. Marceline identified herself as a midwife and commented that in her practice they see approximately 60-65 women per year and their collaborative efforts are through Kaiser. Ms. Marceline includes in their OSHPD statistics related to physician supervision, clients who transfer (to her practice) because the physician chooses not to be involved if the client is planning a home birth. It is her opinion that the statistics that are completed every year, do not make a good case for how much collaboration is actually occurring.

Dr. Gregg stated that there are physicians who collaborate with midwives “underground” and do so at their own peril. She further stated she would be willing to collaborate with midwives if the regulation was better defined. She felt that more physicians would “step up to the plate” if they would not be put at risk, and the “collaborative relationship” between physician and licensed midwife was better defined.

Ms. Ehrlich asked for Dr. Gregg’s assistance in revising the drafted physician supervision language. Dr. Gregg defined collaboration as “midwife-directed physician consultation.” Dr. Gregg’s opinion is physicians are covered under liability carriers if they have face-to-face interaction with a patient. If physicians perform an exam and provides an opinion, they are covered. Physicians do not have liability coverage when they provide advice to a midwife over the phone. If anything happened during a pregnancy, the assumption is, the client would bring suit against the physician because that is generally the person who has liability coverage.

Ms. Sparrevohn mentioned that in the physician’s office where she works, a high risk client would be referred to a perinatologist for consultation. She further added that by defining the collaborative relationship as a “midwife-directed doctor consultation,” the physicians may be more on board. Dr. Gregg mentioned that they often see documentation in the chart referencing whether a relationship is ongoing or if it is a one-time consultation. Ms. Ehrlich stated that she would like language in the regulation to make clear that there would be no physician liability until transfer of care.

Mr. Heppler advised that when the Board and all of its Committees practice these types of exercises for licensing or for disciplinary functions, it does so with consumer protection being paramount. In Mr. Heppler’s opinion, when the Board disciplines a licensee or denies a license, it does so with the purpose to protect the public. He further stated the Board does not deal in civil litigation, as it is not the Board’s duty to award monetary damages. It is not within the arena of the Board to determine or discuss civil litigation and the avoidance of civil litigation. Mr. Heppler asked the MAC to be clear in that trying to shield or promote exposure to legal liability is not the Board’s role. The Board deals in administrative discipline and in public protection.

Ms. Sparrevohn asked Dr. Gregg if no change was made to the proposed physician supervision language, could the midwife and the physician define what collaboration is? She stated ACOG and the liability insurance carriers could identify what would or would not be covered. Dr. Gregg said she believed physicians would be more willing to collaborate if there were standardized procedures instead of the midwife defining the relationship. It comes down to engaging the physicians in this process.

Ms. Smith-Crowley provided information concerning physician costs associated with having to defend himself/herself in a court case. Oftentimes insurance carriers try to prove that it is a collaborative relationship so they do not have to defend the suit. She recommended adding language identifying limited responsibility to the physician would be helpful.

Ms. Sparrevohn asked for legal counsel’s opinion as to whether the draft language could be changed from collaborative to midwife-directed consultation. In response, Ms. Dobbs stated that a motion was on the floor and if Ms. Sparrevohn was considering changing the regulatory language, a request should be made to send the draft back to staff and to have them continue to work on the

language.

Ms. Gibson asked whether the revisions could be made at the time the regulation went to a Hearing.

Mr. Heppler provided a brief overview of the regulatory process. He indicated the MAC would need to bring the recommended language to the Board for approval. The Board would then deliberate on the matter and determine whether it accepts the MAC's recommendation and if so would set the matter for a Hearing.

If the matter was set for a Hearing, there would be a 45 day comment period for the Board to accept written comments. At the Regulatory Hearing, the Board would again accept both oral and written comments. If the Board decided to proceed, all comments would be addressed by the Board. It could take an additional 45 or 50 days if further steps were required due to revisions being made.

Ms. Rock identified herself with the California Association of Midwives (CAM). She suggested midwives who are currently collaborating with physicians be surveyed to find out which of the two drafts of language was preferable from the doctor's viewpoint. Ms. Sparrevohn asked CAM if they could do this and Ms. Rock agreed.

Ms. Sparrevohn asked if there were any more comments from the Council. Mr. Heppler asked if the Council was asking for a motion. He outlined three available options: to forge ahead with the regulation as is, understanding that it may be revised; send it back for revisions; or, amend it now.

Mr. Heppler confirmed that the draft could be amended at the current time. He stated that the pitfall in amending the draft language without additional input from the medical community is that there could be additional change recommendations down the road. Ms. Sparrevohn recommended submitting the original draft proposal to the full Board in October and did not see value in changing the wording of the regulation at the time.

Ms. Yaroslavsky stated that she had made the motion and would prefer to have additional input from other people. In order to move the process forward, she was not willing to pull the motion. She recommended that in the essence of time, it would be better to work out the verbiage at the time rather than waiting. She asked legal staff if there would be any opportunity prior to October to tighten up the draft language since it appeared there wasn't complete agreement from members and ACOG.

In order to consider new language, Ms. Yaroslavsky pulled the original motion to accept the revised language and made a new motion to consider new language; Ms. Gibson who had seconded the motion agreed.

Dr. Gregg summarized ACOG's recommendations: midwives should direct the consultation when necessary, and consultation should be face-to-face between physician and patient. In each case, consultation would not be mandated, but performed when the midwife deems it necessary.

Ms. Ehrlich preferred the verbiage "medical indication" rather than "necessary" as she claims the

word necessary sounds like "high risk." Mr. Heppler questioned whether it would be up to the discretion of the midwife to decide what the medical indications or conditions were to initiate the physician consultation. Council members responded yes.

Additional discussion ensued to edit and enhance the regulatory language.

Dr. Byrne clarified that if it is a consultation, the patient-physician relationship is established with face-to-face contact. By utilizing that language, in a supervisory role or in a hospital-health care system, sending a patient or wanting to send patients (even if they don't show) puts the responsibility on the physician to track them down.

Dr. Gregg recommended from the physician's perspective that section (b) should be restated. She used Utah as an example; there is no liability until there is a face-to-face consult. She was under the impression that the Council was trying to distinguish between face-to-face consultation and midwife/physician consultation, whereas the midwife continues to be the primary care provider until full transfer of care. She said they are relying on the physicians to document this information in their charts.

Ms. Sparrevohn recommended leaving section (b) as is, since the face-to-face takes place prior to the possibility of the patient being transferred. She read section (a) again, "The requirement for physician supervision contained in 2507 of the code is deemed to have been met if the licensed midwife establishes a midwife directed physician/patient consultation for medical indication."

Ms. Ehrlich interjected that the physician must meet the requirements of section 1399.72.

Ms. Sparrevohn requested public comment.

Mr. Ackerman stated that his understanding of the first part of the originally proposed regulatory language implies that the midwife would send all midwifery clients to a physician.

Ms. Sparrevohn clarified that legal staff does not read the regulation in that way and they do not want to direct midwives to have a collaborative relationship with a physician for every client.

Ms. Grote questioned if there was liability protection for the doctor who provides advice over the phone to a midwife with a moderate risk client. Ms. Sparrevohn clarified that the physician is not responsible until care has been transferred from the midwife. Based on comments made by Dr. Gregg and Ms. Smith-Crowley, Ms. Sparrevohn suggested that there probably should not be a phone relationship if the physician intends to be protected. In medical settings, clarification is generally provided in writing.

Ms. Sparrevohn requested a 10 minute recess while staff typed up the edited language. The following draft regulation to Section 1379.23 in Article 3.5 in Chapter 4 of Division 13, Title 16 of the California Code of Regulations was presented. *Council Members voted to approve the language and present to the Board at the October meeting.*

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 establishes a midwife-directed physician-

patient consultation for medical indication. The physician must meet the requirements of Section 1379.22.

- (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 a licensed midwife solely by consulting with or accepting a referral from the licensed midwife.

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

B. 1379.24 - Practice of Midwifery

Council Members were asked to refer to page 14 of their packets concerning the Practice of Midwifery, proposed regulation 1379.24 of the California Code of Regulations. Ms. Lowe stated that current regulations outline the requirement for midwifery education programs. The education program must prepare the midwife for the management of a normal pregnancy, labor, and delivery. Midwives often face difficulty in securing supplies, such as oxygen, anesthetics, and oxytocics in order to practice safely and effectively.

Ms. Lowe provided a brief history concerning the regulation stating that at the December 2011 MAC meeting, legal counsel presented language for the proposed regulation. The MAC members approved the proposed language with minor edits. At the March 29, 2012 Interested Parties Workshop, recommendations were made to remove language pertaining to diaphragms and cervical caps and requested adding, "family planning care" instead. Ms. Lowe requested the following language be approved by the MAC and recommended to the Full Board to set for Hearing:

1379.24. Practice of Midwifery

A licensed midwife shall have the authority, limited to the practice of midwifery as defined in section 2507 of the Code, 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, oxygen, local infiltration, vitamin K, eye prophylaxis, and family-planning care.

NOTE: Authority cited: Section 2018, Business and Professions Code. Reference: Section 2507, Business and Professions Code, and Title 16 California Code of Regulations 1379.30.

Ms. Ehrlich made a motion to recommend to the Board that the revised language be set for Hearing; s/Gibson.

Ms. Sparrevohn asked for input from the Council.

Ms. Ehrlich suggested that instead of stating postpartum oxytocics, it would be better stated as "post antihemorrhagics" and to eliminate either local anesthesia and local infiltration as they mean

the same thing.

Ms. Sparrevohn recommended eliminating local anesthesia from the regulation. Ms. Gibson clarified that local anesthesia is used to do infiltration.

Dr. Byrne questioned the phrase, "family-planning care" stating that with so many options considered invasive, he was concerned the current language was overly broad as it could imply IUD insertions, sub dermal implants, and tubal obstruction. Ms. Sparrevohn referred to the Midwives Standard of Care that allows a midwife to add skills to her practice if she has appropriate physician backup. She indicated the midwife is able to perform an IUD insertion with a physician available, while working in a clinical setting and feels that having a physician as backup should be adequate to allow a midwife to do this. Dr. Byrne agreed, but questioned whether that should be extended to sub-dermal implants and other invasive procedures, since such procedures have evolved over the last ten years.

Ms. Yaroslavsky asked if there should be more definition by outlining the scope of the appropriate level of training and the appropriate level of back up.

Ms. Dobbs recommended adding "subject to appropriate training and skill level."

Ms. Sparrevohn suggested referencing the Midwifery Standard of Care Sections (1)(J) in the family planning care.

Ms. Dobbs voiced concern over the current verbiage which seemed to suggest midwives are allowed to write prescriptions, even though it does not specifically say prescription. Ms. Ehrlich stated that midwives were authorized to obtain and administer only the specific drugs, devices and diagnostics outlined in the regulation and that midwives usually obtain supplies through supply houses or occasionally from a pharmacy, hospital, or physician. She said midwives were authorized to utilize the items identified in regulation. Ms. Dobbs suggested replacing the word "obtain" with "utilize."

Ms. Sparrevohn identified the big issue is how midwives obtain supplies. Ms. Yaroslavsky questioned whether the issue of not being able to obtain supplies caused the regulation to be written in the first place. Ms. Gibson acknowledged that it was. Ms. Yaroslavsky clarified that midwives can receive the supplies needed to do their job. She agreed that the word "obtain" should be changed.

Mr. Heppler reminded attendees the purpose of the regulation was to reconcile the educational requirements, regulatory practice requirements, and some of the statutes involving midwifery training. He conveyed issues in the pharmacy law that did not identify licensed midwives having the authority to issue prescriptions. The regulation states, "If a prescription is something that is either signed or issued by a physician, a dentist, an optometrist, a podiatrist, a veterinarian, a naturopathic doctor, a PA, nurse practitioner or a certified nurse midwife." Mr. Heppler stated that there were practical limitations per section 4040 of the Business and Professions Code, and based on the pharmacy code, midwives may not be able to acquire supplies through these means. He recommended moving ahead with the midwifery regulation. The issue comes down to whether the pharmacist could fill it or elect not to fill it. Ms. Ehrlich confirmed that midwives do have the

ability to get supplies through supply houses because other states have formularies to assist practitioners.

Ms. Sparrevohn listed supplies that are prescription driven and are a problem to obtain: RhoGAM, oxygen, lidocaine, vitamin K, prophylaxis, and oxytocics. She asked if all of these supply houses were in compliance with the law or not. She recommended looking into fixing this problem for midwives.

Ms. Ehrlich acknowledged that ultimately statutory changes needed to be made; however, she recommended moving ahead with the proposed language at this time.

Ms. Yaroslavsky asked if utilizing the word "furnish" would be a better definition since the supplies are not furnished by a pharmacy. She also recommended removing the word "drug" since the term is associated with pharmacology. Ms. Sparrevohn suggested the revised language should state, "to obtain and administer," and recommended the following changes: remove the word "drug"; change oxytocics to "anti-hemorrhagics"; remove local infiltration; and, end the paragraph with "family-planning care in accordance with (1)(J) of the Standard of Care for Licensed Midwives".

Ms. Sparrevohn asked for public comment on the regulation. No comments were provided.

As the maker of the motion and the second of the motion Ms. Ehrlich and Ms. Gibson accepted the revised language. Council Members voted to approve the language and present it to the Board at the October meeting.

1379.24. Practice of Midwifery

A licensed midwife shall have the authority, limited to the practice of midwifery as defined in section 2507 of the Code, to obtain and administer 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 anti-hemorrhagics, RhoGAM, local anesthesia, oxygen, vitamin K, eye prophylaxis, and family-planning care in accordance with section (1)(J) of the Standard of Care for Licensed Midwives.

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

Reference: Section 2507, Business and Professions Code, and Title 16 California Code of Regulations 1379.30.

Agenda Item 5: Midwifery Program Update

A. Licensing Statistics

Ms. Morrish provided an update on the fourth quarter statistics for fiscal year 2011/2012 indicating that there were nine licenses issued, 37 licenses renewed, and zero applications pending.

B. 2011 Licensed Midwife Annual Report

Ms. Morrish provided an update on the 2011 Licensed Midwife Annual Report stating that as of June 30, 2012, there were 267 midwives with current/renewed status and 30 with delinquent status. Those in delinquent status did not include canceled, surrendered or revoked licenses. Of the 283 midwives that were expected to report, 241 submitted statistics to the Office of Statewide Health Planning and Development (OSHPD). There were 42 midwives who did not file a report. The Board sent out deficiency letters to remind midwives that the Licensed Midwife Annual Report (LMAR) was past due.

Ms. Morrish indicated that the Board hosted the North American Registry of Midwives (NARM) exam on August 15, 2012, in which nine individuals sat for the exam. Ms. Morrish informed the Council that the next exam was scheduled for February 15, 2013.

C. Enforcement Statistics Report

Ms. Morrish provided an update on the enforcement statistics stating that there were a total of 26 complaints received for Fiscal Year 2011/2012. Twenty complaints were related to licensed midwives and six concerned unlicensed midwives. The Complaint Unit closed 17 complaints.

Ms. Sparrevohn inquired as to how many closed complaints involved licensed versus unlicensed midwives. She also asked how many licensed versus unlicensed midwives were referred for criminal action. Ms. Morrish did not have the specific breakdown at the time but indicated that this information could be provided in the future.

Ms. Sparrevohn recommended that in the future it would be useful for the statistics to reflect licensed versus unlicensed midwives. Ms. Yaroslavsky reiterated the importance of keeping separate statistics for licensed and unlicensed midwives.

Agenda Item 6: Update on Task Force for Midwifery Students/Midwife Assistants

Ms. Lowe provided an update on the Task Force for Midwifery Students and Midwife Assistants. During the March 29, 2012 MAC meeting a recommendation was made to create a Task Force to determine regulations for midwife students and assistants. The meeting was scheduled for September 13, 2012 at the Board and notification was posted on the Board's website. The goal of the meeting was to discuss the apprenticeship model.

Ms. Sparrevohn asked for comment from Council Members.

Ms. Yaroslavsky recommended it would be beneficial to review the apprenticeship models used by other states to get a broader picture of the situation. Ms. Lowe stated that reference material would be provided for the Task Force meeting. Ms. Lowe confirmed Ms. Gibson was identified as a task force member.

Ms. Sparrevohn asked for public comments; none were provided.

Agenda Item 7: Consideration of Nizhoni Institute Advanced Placement and Transfer or Credit Proposal.

Mr. Worden stated that staff were not prepared to provide an update to Council Members on the Advanced Placement Proposal provided by the Nizhoni Institute at the time because the proposal

was still under staff review.

Ms. Sparrevohn asked for public comments; none were provided.

Agenda Item 8: Discussion and Possible Recommendation to the Full Board on MAC Term Limits

Ms. Sparrevohn requested the Council consider adopting the following term limits: two, three year terms per Council Member.

She mentioned the term limits for Chair and Vice Chair were unclear and opened the topic up for discussion.

Ms. Yaroslavsky asked if members could serve again after their consecutive terms were up if a period of time had lapsed between appointments.

Ms. Ehrlich raised concern that with term limits there is a loss of institutional memory and knowledge on how things have come about and how decisions have been made in the past. Ms. Sparrevohn pointed out the terms do not expire at the same time and institutional memory can come from the public who attend the meetings. Her concern is that without term limits, it will be hard for new people to get the opportunity to serve and provide fresh ideas on the Council. Ms. Gibson mentioned that her term is up in March 2013, rather than June 30, 2014, as was stated in the meeting materials.

Ms. Yaroslavsky voiced her opinion that term limits are not beneficial in a democracy, and she believes the issue is not so much about term limits but rather engaging the broader community to participate beyond the day-to-day level with a governing body. She questioned why the two year terms were previously eliminated. Ms. Sparrevohn stated that the terms were adjusted to create staggered expiration dates. Ms. Yaroslavsky noted that participants who have been involved from the beginning, like Dr. Gregg, continue to be involved. She stated that it was a good opportunity for ex-official members to participate and stay involved as audience members. She also stated that there are opportunities to chair Task Force meetings, etc., to get a variety of opinions at the table to institute change.

Mr. Heppler stated that the Council has no statutory limit on the number of members and the Council could request the Board to add additional members since there are no number restrictions. If the Council members decided that they needed new input besides conducting task force and interested parties meetings, they could expand or contract members as they see fit.

Ms. Yaroslavsky stated that an increase in the size of the Council was a good idea and ex-official members should be involved or appointed to subcommittees. She recommended having volunteers in place to help support staff to research and culminate national and international information and she suggested the MAC Chairperson meet with Board staff and legal counsel to set that up. Ms. Sparrevohn stated that she is looking for participation from the public and other midwives so as not to lose the history of the Council.

Ms. Sparrevohn indicated that the MAC did not want to enact term limits for the members.

Ms. Sparrevohn asked how long the term limits have been for the Chairperson. Members stated that the time frames have varied but recommended term limits should be two years. Ms. Yaroslavsky recommended the Chairperson give thought to this issue and discuss with staff before providing a recommendation to the MAC.

Ms. Sparrevohn made a motion to set two year term limits for officers; s/Ehrlich.

Ms. Yaroslavsky asked Ms. Sparrevohn to outline her perspective. Ms. Sparrevohn clarified by stating the issue of term limits has been discussed and she would set the term in office at two years without term limits. Mr. Heppler asked Ms. Sparrevohn if she was making no limit to the terms served as a MAC member, clarifying that she was making a term limit for an officer. Ms. Sparrevohn stated she was attempting to identify the length of term since it had not been previously identified.

Council Members voted to approve two year term limits for officers.

Agenda Item 9: Agenda Items for the December 6, 2012 Midwifery Advisory Council Meeting

Ms. Gibson voiced concern with data discrepancies on the OSHPD Licensed Midwife Annual Report. Ms. Sparrevohn asked Mr. Worden to look into the issue. Mr. Worden stated that staff would meet with OSHPD once the change recommendations were identified. He further clarified that the Board's Information Systems staff were working to incorporate a new computer system at the Board and currently do not have the time to work on changing the LMAR. Staff are also involved in preparing the Annual and Sunset Review Reports, but should be able to focus on addressing these issues in the next month or two.

Some MAC members voiced concern that they had hoped the recommended changes would be in the works. Mr. Worden mentioned, due to deadlines, staff have had to prioritize workload.

Ms. Sparrevohn asked if there were additional items to place on the agenda for the next meeting.

Dr. Byrne asked for an overview of the goals and objectives related to the data reporting processes.

The following agenda items were identified by Ms. Sparrevohn for the December 6, 2012 MAC meeting:

- Midwifery Program Statistics
- Student Assistants Task Force Update
- MANA Task Force Update
- OSHPD LMAR Update
- An Overview of the Goals and Objectives related to Data Reporting

Agenda Item 10 Adjournment

Ms. Sparrevohn made a motion to adjourn the meeting. Motion carried, adjourned at 3:49 p.m.





MEDICAL BOARD OF CALIFORNIA
Licensing Operations



Midwifery Advisory Council

Lake Tahoe Room
2005 Evergreen Street
Sacramento, CA 95815

March 14, 2013
MINUTES

Agenda Item 1 Call to Order/Roll Call

The Midwifery Advisory Council (MAC) of the Medical Board of California (Board) was called to order by Chair Carrie Sparrevohn at 1:07 p.m. A quorum was present and notice was sent to interested parties.

Members Present:

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

Staff Present:

Diane Dobbs, Department of Consumer Affairs, Legal Counsel
David Galbraith, Assistant
Kurt Hepler, Staff Counsel
Kimberly Kirchmeyer, Deputy Director
Natalie Lowe, Licensing Manager
Susan Morrish, Licensing Analyst
Anthony Salgado, Licensing Manager
Curt Worden, Chief of Licensing

Members of the Audience:

Jennifer Brown, L.M.
Yvonne Choong, CMA
Fiaura Conen
Sarah Davis, C.A.M.
Rachel Fox-Tierney, L.M.
Joscelyn Grole, C.A.M.
Brent Keime, Nizhoni Institute
Brooke Lonegan
Tosi Marceline, L.M.
Laura Nichols, C.A.M.
Laura Perez, Sacred Birth Place

Debra Puterbaugh, C.A.M.
Constance Rock, L.M., C.A.M.
Shannon Smith-Crowley, A.C.O.G.
Krystel Viehmann, C.A.M.

(The above list identifies attendees who signed the meeting sign-in sheet)

Agenda Item 2 Public Comment on Items Not on the Agenda

No public comment was provided.

Agenda Item 3 Approval of the Midwifery Advisory Council Meeting Minutes

A. August 30, 2012

Ms. Sparrevohn recommended tabling approval of the August 30, 2012 meeting minutes until the August 8, 2013 MAC meeting, as change recommendations from Ms. Ehrlich were unavailable for staff to review prior to the meeting. Ms. Smith-Crowley expressed concern that her comments regarding physician supervision and collaboration, (identified on page 4 of the August 30, 2012 minutes), stated the opposite of what she meant.

Ms. Sparrevohn made a motion to table the August 30, 2012 meeting minutes; s/Ehrlich; motion carried.

B. December 6, 2012

Ms. Ehrlich provided name clarification to the acronym for MEAC, which was misidentified on page 8 of the December 2012 meeting minutes. Ms. Ehrlich also mentioned she was unable to locate the webcast for the December 6, 2012 MAC meeting on the Medical Board's Web site. Ms. Lowe clarified that the archived webcast meetings were available through the Department of Consumer Affairs Web site and also viewable on YouTube. Ms. Yaroslavsky recommended the meeting webcasts should be listed on the Medical Board's Web site with instructions on how to access it.

Ms. Dobbs requested a correction to the verbiage on page 2 of the December 2012 meeting minutes pertaining to publicly noticed meetings.

Ms. Sparrevohn made a motion to accept the December 6, 2012 meeting minutes with corrections; s/Webster; motion carried.

Agenda Item 4 Report from the Midwifery Advisory Council Chairperson

Ms. Sparrevohn provided an update of the February 2013 Quarterly Board meeting. For midwifery reporting purposes, she requested to the Board, utilizing the Midwives Alliance of North America (MANA) data collection tool. Ms. Sparrevohn mentioned the idea was well received by the Board and she would like to explore the idea of seeking a Statute change to incorporate the MANA statistics. Ms. Sparrevohn took the opportunity to thank the certified nurse midwives and licensed midwives for attending the meeting and engaging in the process.

Agenda Item 5 Sunset Review Update

- A. Status of Proposed Adoption of CCR §1379.23 - Physician Supervision Requirement
- B. Status of Proposed Adoption of CCR § 1379.24 - Practice of Midwifery; Drugs and Devices

- C. Recommendation to Identify Certified Nurse Midwives as Licensed Healthcare Providers Sanctioned to Supervise Student Midwives
- D. Use of the M.A.N.A Reporting System

Ms. Lowe directed attendees to page 30 in the meeting packets and provided background information on current Sunset Review processes. She outlined that the Board submitted the original Sunset Review Report to the Legislature's Senate Business and Professions Economic Development Committee. Several members of the midwifery committee, and Shannon Smith-Crowley from the American Congress of Obstetricians and Gynecologists (ACOG) provided testimony to the Legislature. Ms. Lowe mentioned ACOG will sponsor Assembly Bill 1308 to address concerns pertaining to midwifery supervision and midwife billing concerns. She stated that the Board will also be working with ACOG on the Bill.

Based on material provided at the Hearing, the Board anticipates receiving written feedback from the Committee requiring additional information. Ms. Lowe informed the MAC they should be prepared to answer specific questions that may come up, such as how the costs associated with the implementation of the MANA reporting process will be covered, and how MANA will transfer data to the Office of Statewide Health Planning and Development (OSHPD).

Ms. Lowe stated that updates regarding the Sunset Review will be provided to the Council as information is made available.

Ms. Ehrlich asked if the next meeting would be a follow-up meeting by the Legislature or a meeting the Medical Board would hold. Ms. Lowe replied, that an additional meeting had not been scheduled, but anticipated a response from the Legislature with written inquiries. In answer to Ms. Ehrlich's question, Ms. Sparrevohn said it was not known if a follow-up Hearing would be scheduled. She stated that at the Board's Quarterly meeting, members were interested in actual cost information to implement the MANA project and recommended the MAC should be prepared with more finite cost information, if necessary.

Mr. Worden concurred that the meeting had been very positive and the Committee was receptive to the midwifery community and the issues that were presented. Ms. Yaroslavsky echoed the sentiment that there is a cognizant understanding within the Legislature that doctors will not be the only ones providing birthing services and that the midwifery movement is moving forward.

Public comment was provided for this agenda item.

Ms. Choong with the California Medical Association (CMA) provided additional information regarding the Sunset Review process. She mentioned that an Assembly Bill will be forthcoming that will address several matters within the one bill. She clarified that there may be a separate bill for the more controversial issues in the Sunset Review. Scheduled hearings for those bills will be the next step in the Sunset Review process. Legislative updates regarding the process could be found at www.leginfo.ca.gov. She clarified that the information would be available on the Senate website and not on the Medical Board's website, and offered to send bill information to Council members once the material was available. She

also stated that other questions may surface at the Hearing but the Medical Board would have thirty days to respond to the Legislator's questions.

Ms. Smith-Crowley with ACOG, stated that ACOG is sponsoring a bill with assembly member Susan Bonilla to put a focal point on the issues and to open conversation and collaborative efforts with others. She emphasized, because the current bill cycle is not the usual two year time frame, a real impetus exists to get the bill through this year. The bill will work in tandem with AB1308. Her expectation is, if the two bills are in agreement on some of the issues, and don't need to be addressed by the Board, the language in the bills will get resolved through a technical process. The bill is in the Assembly and was expected to be heard in the Business and Professions Committee in April 2013. Her understanding is, the bill will move out of the Assembly by June 6, 2013. She stated there were multiple issues that would need to be worked through within the next three months and would like to see a collaborative effort in sponsoring the bill.

Due to the Open Meeting Act, ACOG is not able to work directly with the MAC. Ms. Smith-Crowley suggested ACOG could work with the California Association of Midwives (CAM) and the nurse midwives in working through "outcome" reporting issues. She mentioned the Commissioner with the Department of Insurance is interested in the Federal Government's Affordable Care Act (ACA), and the options would include covering midwife care.

Ms. Smith-Crowley believes liability coverage is important as physicians must have liability coverage when working with out-of-hospital patients and midwives. In her opinion, how the liability coverage issues are handled will dictate and define the working relationship between physicians and midwives. She suggested, the physician/midwife relationship must be "above board" and not behind the scenes and suggested looking into the different liability coverage models that are available to midwives so that they can participate as Medi-Cal providers and contract with managed care plans.

Ms. Sparrevohn cited the high cost of liability insurance is prohibitive for midwives to acquire insurance and asked Ms. Smith-Crowley if the ACA money would eliminate that as an issue. Ms. Smith-Crowley advised the need for a self-perpetuating system even if ACA money is available. She suggested liability insurance may become affordable if incomes rise for midwives.

She also mentioned preliminary interest from the University of California for available grant money to look into innovative relationships. ACOG also plans on speaking with obstetricians and gynecologist at several facilities. She again suggested, the importance of "outcome reporting" workgroups and proposed a dual system of state reporting between MANA and OSHPD that would be similar to the state of Vermont. In her opinion, physician liability issues should be a measurement identified on the report. Ms. Sparrevohn stated, physician data has been collected and may not be necessary in the future. When asked, Ms. Sparrevohn confirmed that there was not a cost to midwives to report statistics to MANA.

Referencing appendix (e) of the MANA Report, Ms. Smith-Crowley said that a number of items, including reasons for transfers are not contained in the summary. Multiple births are identified collectively, rather than reported separately.

When Ms. Yaroslavsky asked if a task force should be formed, Ms. Smith-Crowley stated that the task force should conform to the Open Meeting Act, and recommended assembling a workgroup for collaborative input to address the issues in the bill. She has been in contact with Ms. Rock, a representative from the California Association of Midwives (CAM), and would like to include Ms. Dow to represent the certified nurse midwives (CNM). She also suggested including Ms. Choong from CMA. She added that through this process they will be able to come to the right answer. Ms. Yaroslavsky asked Ms. Smith-Crowley if she was organizing the effort, and suggested having a conversation around the end of May 2013.

Ms. Sparrevohn also mentioned that they could form a task force or workgroup as part of the MAC and asked if there was staff availability for this. Mr. Worden described the current difficulty in devoting staff time to this endeavor. Ms. Sparrevohn suggested moving forward on the task force sooner rather than later. Ms. Gibson volunteered to sit on the task force even though she was retiring from the MAC. Ms. Smith-Crowley suggested the need to work through the issues by the end of June because the bill will move over to the Senate.

Ms. Sparrevohn enlisted the lead roles of the task force to Ms. Smith-Crowley and the CAM representatives.

Ms. Choong confirmed CMA support for Ms. Smith-Crowley's recommendation to establish a sub-committee and cited conversations that have occurred between CMA and ACOG as moving in the right direction. She suggested including midwives and other allied health care professionals in the collaborative and consultation process and recommended taking the time to address the concerns in the right way by not making hasty decisions.

Ms. Choong concurred with looking at liability coverage issues as it will help distinguish what is and is not possible in developing long term solutions to the problem. She also recommended the sub-committee take the approach to address midwifery as a very legitimate profession and establishing similar reporting requirements as have been established for other health care professionals. Ms. Choong cited interest in the development of long term solutions that will collectively work for midwives, physicians, and the public.

Ms. Tinkleburg, a nurse-midwife in attendance, stated that she was planning on opening a birth center in conjunction with a Medi-Cal managed care company. She mentioned the difficulty for midwives to obtain medical liability insurance and how the CEO of the company she works for was trying to obtain coverage through a Medi-Cal managed care company they are working with. She informed listeners that the managed care company can collect all data and set up templates for existing databases, making it easier to collect MANA data.

Ms. Brooks introduced herself as the director of a free standing birth center and the president of the Association for Healthcare Documentation Integrity (AHDI). She expressed double-reporting concerns with the MANA and OSHPD systems. She believes both reporting forms are too complex and do not provide the data that is needed. She suggested using the Perinatal Advisory Council (PAC/LA) report because it is comprehensive in that the organization has gathered data from southern California hospitals for many years and is a comprehensive report.

Ms. Brooks indicated the purpose of the reporting forms were to gather information to make things better for patients, and address improvements in outcomes and the quality of care that is provided. She indicated that if the forms are too complex or confusing, and they don't separate specific information, outcome measurements are unclear. With two Senate bills coming out, Ms. Brooks would like to see midwives integrated into the health care system and wanted the Council to consider another reporting option.

Ms. Gibson asked Ms. Brooks if Council members could receive a copy of the reporting form from PAC/LA. Ms. Brooks agreed to provide this information to the Council.

Ms. Gibson expressed concern with wording in the Sunset Review Report, (page 45 of the meeting packet), which pertains to limitations placed on a midwife's ability to practice independently of physician supervision. She wanted to clarify that midwives do know what works for childbearing women and suggested a midwifery licensing mechanism that allows midwives to meet the needs of childbearing women so that there won't be an increase in the number of women who find themselves attempting unattended births. Ms. Gibson acknowledged the need for a relationship between midwives and physicians that works for all, including tax payers.

Ms. Sparrevohn agreed with Ms. Gibson's statement and added, the concern is about safety, ease of transport, and consultation when needed with an obstetrician, perinatal or neonatologist. She disagrees with the wording in the report and clarified that midwives view themselves as practitioners, wanting good working relationships with physicians.

Agenda Item 6 Program Update

At the December 6, 2012 MAC meeting an update was provided on the Student Assistant Task Force. During this meeting, staff was asked to provide an update at the next meeting to identify regulations pertaining to student assistants that could be changed. Ms. Lowe provided a brief update indicating that the Midwifery Student/Assistant regulatory concerns were included in the Sunset Review Report and the Board will await word from the Legislature on how to proceed. No further action would be taken by Board staff at this time.

On February 20, 2013, there were nine individuals who sat for the North American Registry of Midwives (NARM) exam. The next exam is scheduled for August 15, 2013.

Please note: The next exam date was changed to August 21, 2013 at the request of NARM.

A. Licensing Statistics

Ms. Lowe provided an overview of the licensing statistics for the second quarter, October 1st through December 31st, 2012. The Board received twelve new Licensed Midwife applications and twelve new licenses were issued. At the end of the quarter 286 licenses were in renewed and current status with 24 in delinquent status.

Ms. Ehrlich mentioned that she had noticed the name of a licensed midwife in delinquent status, who was actually deceased, identified on the Board's license look up site. She asked what the process was to have the information updated on the Board's website. Ms. Lowe outlined certain procedures must be followed to update the Board's records and clarified that

the license would stay in delinquent status until information could be verified. She agreed to look into the situation if the name was provided. She further explained, if the Board was unable to verify the information, the license would stay in delinquent status for five years from the expiration date, and then would show cancelled status.

Ms. Yaroslavsky asked why it takes five years to cancel a license and if the time frame could be shorter. Mr. Worden clarified that five years is identified in Statute.

B. Enforcement Statistics

Ms. Lowe referred Council members to the enforcement statistics identified on page 50 in the meeting packets. During the second quarter of the fiscal year, the Board received two new complaints, both against licensed midwives. There were no new investigations opened during the second quarter; however, one case against a licensed midwife was referred to the Attorney General's Office for prosecution, and three cases were referred for criminal action. Of the three cases, one was against a licensed midwife and the other two were against unlicensed midwives. This concluded Ms. Lowe's update.

Public comment was provided on this agenda item.

Ms. Perez identified herself as a student midwife and mentioned she sat for the NARM exam on February 20, 2013. She clarified there were nine people taking the test, not eight.

Agenda Item 7 Agenda Items for the August 8, 2013 Midwifery Advisory Council Meeting-Sacramento

The following agenda items were identified by Ms. Sparrevohn for the August 8, 2013 MAC meeting:

- Midwifery Program Statistics
- An update on the Sunset Review Report
- Selection of a new MAC member to fill the vacancy of Faith Gibson, L.M.

Agenda Item 8 Adjournment

Ms. Sparrevohn made a motion to adjourn the meeting; motion carried. Meeting was adjourned at 2:09 p.m.





MEDICAL BOARD OF CALIFORNIA
Licensing Program



June 19, 2013

Midwifery Advisory Council Vacancy
Deadline for Applicant Submissions: July 20, 2013

Deadline extended until July 30, 2013
Submissions may be sent electronically to
Susan.Morrish@mbc.ca.gov

ATTENTION: ALL INTERESTED PARTIES

The Medical Board of California (Board) is seeking applications from midwifery licensees for one position on the Midwifery Advisory Council (MAC). The position is available based upon the expired term of one licensed midwife.

The vacant licensed midwife position will be for a three year term that will run through October 2016.

The Board is seeking a qualified licensed midwife who is interested in serving on the MAC. The applicant chosen by the MAC at its August 8, 2013 meeting will be subject to approval by the Board at its October 24-25, 2013 meeting. Service is voluntary; acceptance of a position on the MAC will require future time commitments, including attendance at a minimum of three meetings per year in Sacramento. This is an unpaid position; however, travel expenses will be reimbursed.

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

If you are interested in serving on the MAC, please complete a Member Interest form and return by fax to (916) 263-2487 or by mail to:

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

All Member Interest forms must be received by July 20, 2013 to be considered. If you have any questions concerning this announcement, please contact Susan Morrish at (916) 263-2393 or by email at susan.morrish@mbc.ca.gov.

Sincerely,

Curtis J. Worden
Chief of Licensing

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

Expectations of Membership: The Midwifery Advisory Council (MAC) members volunteer to serve and attend all MAC meetings for up to 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 midwifery, but are not licensed midwives. To be considered for appointment, please mail, e-mail, or fax your Interest Form by July 20, 2013 to:

Medical Board of California
 2005 Evergreen Street, Suite 1200
 Sacramento, CA 95815
 Attention: Midwifery Program
 FAX: (916) 263-8936
 Susan.Morrish@mbc.ca.gov

If you have any questions please contact Susan Morrish 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 # _____

Are you a California Licensed Physician?: YES NO (Check only one) License Number: _____
 If yes, are you currently practicing as an obstetrician/gynecologist? YES NO (Check only one)

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

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

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

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

(Signature)

(Date)

DISCLOSURE: Providing this information is strictly voluntary. The personal information requested on this form is being collected for consideration of appointment as a member of the Midwifery Advisory Council. This information will be reviewed by the Board staff and members of the Board and/or Midwifery Committee. This form will be retained in the files of the Licensing Program. This position is voluntary and will require future time commitments. This form and attachments must be returned no later than July 20, 2013.

AMENDED IN SENATE JULY 9, 2013

AMENDED IN SENATE JUNE 13, 2013

AMENDED IN ASSEMBLY MARCH 21, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL

No. 1308

Introduced by Assembly Member Bonilla

February 22, 2013

An act to amend Sections 2507 and 2508 of the Business and Professions Code, and to amend Section 1204.3 of the Health and Safety Code, relating to professions and vocations.

LEGISLATIVE COUNSEL'S DIGEST

AB 1308, as amended, Bonilla. Midwifery.

Existing law, the Licensed Midwifery Practice Act of 1993, provides for the licensing and regulation of midwives by the Board of Licensing of the Medical Board of California. The license to practice midwifery authorizes the holder, under the supervision of a licensed physician and surgeon, as specified, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother, and immediate care for the newborn. Under the act, a licensed midwife is required to make certain oral and written disclosures to prospective clients. A violation of the act is a crime.

This bill would additionally authorize a licensed midwife to directly obtain supplies and devices, obtain and administer drugs and diagnostic tests, order testing, and receive reports that are necessary to his or her practice of midwifery and consistent with his or her scope of practice and would require a licensed midwife to disclose to prospective clients the specific arrangements for referral of complications to a physician

and surgeon. *Because a violation of that requirement would be a crime, the bill would impose a state-mandated local program.*

Existing law requires the board, by July 1, 2003, to adopt regulations defining the appropriate standard of care and level of supervision required for the practice of midwifery.

~~This bill would require the board, by July 1, 2015, to revise and adopt regulations defining the appropriate standard of care and level of supervision required for the practice of midwifery and identifying complications necessitating referral to a physician and surgeon delete that requirement.~~

Existing law requires a licensed alternative birth center, and a licensed primary care clinic that provides services as an alternative birth center, to meet specified requirements, including requiring the presence of at least 2 attendants during birth, one of whom shall be either a physician and surgeon or a certified nurse-midwife.

This bill would provide that a licensed midwife may also satisfy that requirement.

~~By expanding the disclosures a licensed midwife is required to make to prospective clients, this bill would expand the scope of a crime thereby imposing a state-mandated local program.~~

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

- 1 SECTION 1. The Legislature finds and declares the following:
- 2 (a) Licensed midwives have been authorized to practice since
- 3 1993 under Senate Bill 350 (Chapter 1280 of the Statutes of 1993),
- 4 which was authored by Senator Killea. Additional legislation,
- 5 Senate Bill 1950 (Chapter 1085 of the Statutes of 2002), which
- 6 was authored by Senator Figueroa, was needed in 2002 to clarify
- 7 certain practice issues. While the midwifery license does not
- 8 specify or limit the practice setting in which licensed midwives
- 9 may provide care, the reality is that the majority of births delivered
- 10 by licensed midwives are planned as home births.

1 (b) Planned home births are safer when care is provided as part
2 of an integrated delivery model. For a variety of reasons, this
3 integration rarely occurs, and creates a barrier to the best and safest
4 care possible. This is due, in part, to the attempt to fit a midwifery
5 model of care into a medical model of care.

6 SEC. 2. Section 2507 of the Business and Professions Code is
7 amended to read:

8 2507. (a) The license to practice midwifery authorizes the
9 holder, under the supervision of a licensed physician and surgeon,
10 to attend cases of normal childbirth and to provide prenatal,
11 intrapartum, and postpartum care, including family-planning care,
12 for the mother, and immediate care for the newborn.

13 (b) As used in this article, the practice of midwifery constitutes
14 the furthering or undertaking by any licensed midwife, under the
15 supervision of a licensed physician and surgeon who has current
16 practice or training in obstetrics, to assist a woman in childbirth
17 so long as progress meets criteria accepted as normal. All
18 complications shall be referred to a physician and surgeon
19 immediately. The practice of midwifery does not include the
20 assisting of childbirth by any artificial, forcible, or mechanical
21 means, nor the performance of any version.

22 (c) As used in this article, "supervision" shall not be construed
23 to require the physical presence of the supervising physician and
24 surgeon.

25 (d) The ratio of licensed midwives to supervising physicians
26 and surgeons shall not be greater than four individual licensed
27 midwives to one individual supervising physician and surgeon.

28 (e) A midwife is not authorized to practice medicine and surgery
29 by this article.

30 (f) A midwife is authorized to directly obtain supplies and
31 devices, obtain and administer drugs and diagnostic tests, order
32 testing, and receive reports that are necessary to his or her practice
33 of midwifery and consistent with his or her scope of practice.

34 ~~(g) The board shall, not later than July 1, 2015, revise and adopt~~
35 ~~in accordance with the Administrative Procedure Act (Chapter 3.5~~
36 ~~(commencing with Section 11340) of Part 1 of Division 3 of Title~~
37 ~~2 of the Government Code), regulations defining the appropriate~~
38 ~~standard of care and level of supervision required for the practice~~
39 ~~of midwifery and identifying complications necessitating referral~~
40 ~~to a physician and surgeon.~~

1 SEC. 3. Section 2508 of the Business and Professions Code is
2 amended to read:

3 2508. (a) A licensed midwife shall disclose in oral and written
4 form to a prospective client all of the following:

5 (1) All of the provisions of Section 2507.

6 (2) If the licensed midwife does not have liability coverage for
7 the practice of midwifery, he or she shall disclose that fact.

8 (3) The specific arrangements for the referral of complications
9 to a physician and surgeon for consultation. The licensed midwife
10 shall not be required to identify a specific physician and surgeon.

11 (4) The specific arrangements for the transfer of care during the
12 prenatal period, hospital transfer during the intrapartum and
13 postpartum periods, and access to appropriate emergency medical
14 services for mother and baby if necessary.

15 (5) The procedure for reporting complaints to the Medical Board
16 of California.

17 (b) The disclosure shall be signed by both the licensed midwife
18 and the client and a copy of the disclosure shall be placed in the
19 client's medical record.

20 (c) The Medical Board of California may prescribe the form for
21 the written disclosure statement required to be used by a licensed
22 midwife under this section.

23 SEC. 4. Section 1204.3 of the Health and Safety Code is
24 amended to read:

25 1204.3. (a) An alternative birth center that is licensed as an
26 alternative birth center specialty clinic pursuant to paragraph (4)
27 of subdivision (b) of Section 1204 shall, as a condition of licensure,
28 and a primary care clinic licensed pursuant to subdivision (a) of
29 Section 1204 that provides services as an alternative birth center
30 shall, meet all of the following requirements:

31 (1) Be a provider of comprehensive perinatal services as defined
32 in Section 14134.5 of the Welfare and Institutions Code.

33 (2) Maintain a quality assurance program.

34 (3) Meet the standards for certification established by the
35 American Association of Birth Centers, or at least equivalent
36 standards as determined by the state department.

37 (4) In addition to standards of the American Association of Birth
38 Centers regarding proximity to hospitals and presence of attendants
39 at births, meet both of the following conditions:

1 (A) Be located in proximity, in time and distance, to a facility
2 with the capacity for management of obstetrical and neonatal
3 emergencies, including the ability to provide cesarean section
4 delivery, within 30 minutes from time of diagnosis of the
5 emergency.

6 (B) Require the presence of at least two attendants at all times
7 during birth, one of whom shall be a physician and surgeon, a
8 licensed midwife, or a certified nurse-midwife.

9 (5) Have a written policy relating to the dissemination of the
10 following information to patients:

11 (A) A summary of current state laws requiring child passenger
12 restraint systems to be used when transporting children in motor
13 vehicles.

14 (B) A listing of child passenger restraint system programs
15 located within the county, as required by Section 27362 of the
16 Vehicle Code.

17 (C) Information describing the risks of death or serious injury
18 associated with the failure to utilize a child passenger restraint
19 system.

20 (b) The state department shall issue a permit to a primary care
21 clinic licensed pursuant to subdivision (a) of Section 1204
22 certifying that the primary care clinic has met the requirements of
23 this section and may provide services as an alternative birth center.
24 Nothing in this section shall be construed to require that a licensed
25 primary care clinic obtain an additional license in order to provide
26 services as an alternative birth center.

27 (c) (1) Notwithstanding subdivision (a) of Section 1206, no
28 place or establishment owned or leased and operated as a clinic or
29 office by one or more licensed health care practitioners and used
30 as an office for the practice of their profession, within the scope
31 of their license, shall be represented or otherwise held out to be
32 an alternative birth center licensed by the state unless it meets the
33 requirements of this section.

34 (2) Nothing in this subdivision shall be construed to prohibit
35 licensed health care practitioners from providing birth related
36 services, within the scope of their license, in a place or
37 establishment described in paragraph (1).

38 SEC. 5. No reimbursement is required by this act pursuant to
39 Section 6 of Article XIII B of the California Constitution because
40 the only costs that may be incurred by a local agency or school

1 district will be incurred because this act creates a new crime or
2 infraction, eliminates a crime or infraction, or changes the penalty
3 for a crime or infraction, within the meaning of Section 17556 of
4 the Government Code, or changes the definition of a crime within
5 the meaning of Section 6 of Article XIII B of the California
6 Constitution.

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MIDWIFERY PROGRAM LICENSING STATISTICS

Licensed Midwives	FY 12/13	Q1	Q2	Q3	Q4
Applications Received	31	8	12	8	3
Applications Pending	2	5	6	8	2
Licenses Issued	31	5	12	5	9
Licenses Renewed	126	31	32	28	35
Licenses Cancelled	0	0	0	0	0

Licensed Midwives	FY 11/12	Q1	Q2	Q3	Q4
Applications Received	31	9	5	8	9
Applications Pending	0	6	3	3	0
Licenses Issued	31	4	8	10	9
Licenses Renewed	123	24	31	31	37
Licenses Cancelled	1	0	0	1	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

MBC Licensing Statistics	
Renewed / Current Status	297
Delinquent Status	24



CALIFORNIA LICENSED MIDWIFE ANNUAL REPORT Summary

as of 7/16/2013 7:23:09 AM

SECTION A - Submission Summary

Number of Midwives Expected to Report	311
Number Reported	272
Number Unreported	39
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	2012

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?	189	83

SECTION D - CLIENT SERVICES

Line No.		Total #
13	Total number of clients served as primary caregiver during this calendar year.	4370
14	Number of clients who left care for a non-medical reason. (DO NOT include these clients in any further categories on this report)	175
15	Total number of clients served whose births were still pending on the last day of this reporting year.	1193
16	Enter the number of clients served who also received collaborative care. IMPORTANT: SEE DEFINITION OF COLLABORATIVE CARE!	2532
17	Enter the number of clients served under the supervision of a licensed physician and surgeon. IMPORTANT: SEE DEFINITION OF SUPERVISION!	296

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	(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	206	1	0	0	30	ORANGE	107	0	0	0
02	ALPINE	1	0	0	0	31	PLACER	32	0	0	0
03	AMADOR	1	0	0	0	32	PLUMAS	1	0	0	0
04	BUTTE	17	0	0	0	33	RIVERSIDE	113	0	0	0
05	CALAVERAS	7	0	0	0	34	SACRAMENTO	88	0	0	0
06	COLUSA	3	0	0	0	35	SAN BENITO	1	0	0	0
07	CONTRA COSTA	47	0	0	0	36	SAN BERNARDINO	112	1	0	0
08	DEL NORTE	0	0	0	0	37	SAN DIEGO	207	0	0	0
09	EL DORADO	22	0	0	0	38	SAN FRANCISCO	173	0	0	0
10	FRESNO	27	0	0	0	39	SAN JOAQUIN	20	0	0	0
11	GLENN	0	0	0	0	40	SAN LUIS OBISPO	79	0	0	0
12	HUMBOLDT	44	0	0	0	41	SAN MATEO	34	0	0	0
13	IMPERIAL	0	0	0	0	42	SANTA BARBARA	142	0	0	0
14	INYO	0	0	0	0	43	SANTA CLARA	69	0	0	0
15	KERN	33	0	0	0	44	SANTA CRUZ	63	0	0	0
16	KINGS	2	0	0	0	45	SHASTA	90	0	0	0
17	LAKE	14	0	0	0	46	SIERRA	0	0	0	0
18	LASSEN	3	0	0	0	47	SISKIYOU	0	0	0	0
19	LOS ANGELES	300	2	0	0	48	SOLANO	7	0	0	0
20	MADERA	5	0	0	0	49	SONOMA	76	0	0	0
21	MARIN	45	0	0	0	50	STANISLAUS	21	0	0	0
22	MARIPOSA	3	0	0	0	51	SUTTER	1	0	0	0
23	MENDOCINO	32	0	0	0	52	TEHAMA	1	0	0	0
24	MERCED	8	0	0	0	53	TRINITY	2	0	0	0
25	MODOC	0	0	0	0	54	TULARE	11	0	0	0
26	MONO	1	0	0	0	55	TUOLUMNE	21	0	0	0
27	MONTEREY	29	0	0	0	56	VENTURA	107	2	0	0
28	NAPA	14	0	0	0	57	YOLO	19	0	0	0
29	NEVADA	79	0	0	0	58	YUBA	7	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	2784
20	Number of completed births in an out-of-hospital setting	2316
21	Breech deliveries	13
22	Successful VBAC's	118
23	Twins both delivered out-of-hospital	4
24	Higher Order Multiples - all delivered out-of-hospital	1

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

Line No.	Code	Reason	Total #
25	G1	Medical or mental health conditions <i>unrelated</i> to pregnancy	5
26	G2	Hypertension developed in pregnancy	27
27	G3	Blood coagulation disorders, including phlebitis	2
28	G4	Anemia	2
29	G5	Persistent vomiting with dehydration	0
30	G6	Nutritional & weight loss issues, failure to gain weight	0
31	G7	Gestational diabetes	9
32	G8	Vaginal bleeding	2
33	G9	Suspected or known placental anomalies or implantation abnormalities	8
34	G10	Loss of pregnancy (includes spontaneous and elective abortion)	50
35	G11	HIV test positive	0
36	G12	Suspected intrauterine growth restriction, suspected macrosomia	8
37	G12.1	Fetal anomalies	10
38	G13	Abnormal amniotic fluid volumes; oligohydramnios or polyhydramnios	9
39	G14	Fetal heart irregularities	6
40	G15	Non vertex lie at term	43
41	G16	Multiple gestation	10
42	G17	Clinical judgment of the midwife (where a single other condition above does not apply)	16
43	G18	Client request	40
44	G19	Other	22

SECTION H - ANTEPARTUM TRANSFER OF CARE, URGENT/EMERGENCY

Line No.	Code	Reason	Total #
45	H1	Non pregnancy-related medical condition	2
46	H2	Severe or persistent headache, pregnancy-induced hypertension (PIH), or preeclampsia	13
47	H3	Isoimmunization, severe anemia, or other blood related issues	1
48	H4	Significant infection	1
49	H5	Significant vaginal bleeding	3
50	H6	Preterm labor or preterm rupture of membranes	44
51	H7	Marked decrease in fetal movement, abnormal fetal heart tones, non-reassuring non-stress test (NST)	6
52	H8	Fetal demise	2
53	H9	Clinical judgment of the midwife (where a single other condition above does not apply)	2
54	H10	Other	2

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

Line No.	Code	Reason	Total #
55	I1	Persistent hypertension; severe or persistent headache	8
56	I2	Active herpes lesion	0
57	I3	Abnormal bleeding	3
58	I4	Signs of infection	7
59	I5	Prolonged rupture of membranes	27
60	I6	Lack of progress; maternal exhaustion; dehydration	248
61	I7	Thick meconium in the absence of fetal distress	23
62	I8	Non-vertex presentation	11
63	I9	Unstable lie or mal-position of the vertex	6
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)	11
66	I12	Client request; request for medical methods of pain relief	46
67	I13	Other	6

SECTION J - INTRAPARTUM TRANSFER OF CARE, URGENT/EMERGENCY

Line No.	Code	Reason	Total #
68	J1	Suspected preeclampsia, eclampsia, seizures	5
69	J2	Significant vaginal bleeding; suspected placental abruption; severe abdominal pain inconsistent with normal labor	3
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)	3
75	J8	Other life threatening conditions or symptoms	0
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	11
78	K2	Repair of laceration beyond level of midwife's expertise	14
79	K3	Postpartum depression	3
80	K4	Social, emotional or physical conditions outside of scope of practice	1
81	K5	Excessive or prolonged bleeding in later postpartum period	4
82	K6	Signs of infection	1
83	K7	Clinical judgment of the midwife (where a single other condition above does not apply)	1
84	K8	Client request	1
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	5
87	L2	Uterine inversion, rupture or prolapse	0
88	L3	Uncontrolled hemorrhage	5
89	L4	Seizures or unconsciousness, shock	0
90	L5	Adherent or retained placenta with significant bleeding	11
91	L6	Suspected postpartum psychosis	0
92	L7	Signs of significant infection	0
93	L8	Clinical judgment of the midwife (where a single other condition above does not apply)	0
94	L9	Other	0

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

Line No.	Code	Reason	Total #
95	M1	Low birth weight	0
96	M2	Congenital anomalies	5
97	M2.1	Birth injury	0
98	M3	Poor transition to extrauterine life	13
99	M4	Insufficient passage of urine or meconium	1
100	M5	Parental request	2
101	M6	Clinical judgment of the midwife (where a single other condition above does not apply)	5
102	M7	Other	3

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	8
104	N2	Signs or symptoms of infection	2
105	N3	Abnormal cry, seizures or loss of consciousness	0
106	N4	Significant jaundice at birth or within 30 hours	0
107	N5	Evidence of clinically significant prematurity	1
108	N6	Congenital anomalies	0
109	N6.1	Birth injury	1
110	N7	Significant dehydration or depression of fontanelles	0
111	N8	Significant cardiac or respiratory issues	10
112	N9	Ten minute APGAR score of six (6) or less	0
113	N10	Abnormal bulging of fontanelles	0
114	N11	Clinical judgment of the midwife (where a single other condition above does not apply)	3
115	N12	Other	1

SECTION O – BIRTH OUTCOMES AFTER TRANSFER OF CARE

Line No.	Reason	(A) Total # of Vaginal Births		(B) Total # of Caesarean Deliveries	
		Code		Code	
MOTHER					
116	Without complication	O1	433	O8	196
117	With serious pregnancy/birth related medical complications resolved by 6 weeks	O2	7	O9	5
118	With serious pregnancy/birth related medical complications <u>not</u> resolved by 6 weeks	O3	2	O10	0
119	Death of mother	O4	0	O11	0
120	Unknown	O5	9	O12	0
121	Information not obtainable	O6	0	O13	0
122	Other	O7	2	O14	0
INFANT					
123	Healthy live born infant	O15	411	O24	162
124	With serious pregnancy/birth related medical complications resolved by 4 weeks	O16	13	O25	7
125	With serious pregnancy/birth related medical complications <u>not</u> resolved by 4 weeks	O17	3	O26	2
126	Fetal demise diagnosed prior to labor	O18	1	O27	0
127	Fetal demise diagnosed during labor or at delivery	O19	2	O28	1
128	Live born infant who subsequently died	O20	2	O29	0
129	Unknown	O21	3	O30	0
130	Information not obtainable	O22	6	O31	0
131	Other	O23	3	O32	0

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)	
		Code		Code		Code	
MOTHER							
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	1	P22	1
140	Infection	P31	0	P39	0	P23	0
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	1	P27	1
145	Information not obtainable	P36	0	P44	0	P28	0
146	Other	P37	0	P45	0	P29	0



