MEDICAL BOARD OF CALIFORNIA
Licensing Operations

MIDWIFERY ADVISORY COUNCIL

March 27, 2014

Medical Board of California
Lake Tahoe Room
2005 Evergreen Street
Sacramento, CA 95815

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 MAC Chair Carrie Sparrevohn at 1:06 p.m. A quorum was present and notice was sent to interested parties.

Members Present:
Carrie Sparrevohn, L.M., Chair
Karen Ehrlich, L.M.
Tosi Marceline, L.M.
Monique Webster
Barbara Yaroslavsky

Members Absent:
James Byrne, M.D.

Staff Present:
Dianne Dobbs, Department of Consumer Affairs, Legal Counsel
Kimberly Kirchmeyer, Executive Director
Natalie Lowe, Licensing Manager
Destiny Pavlacka, Administrative Assistant
Anthony Salgado, Licensing Manager
AnnaMarie Sewell, Licensing Analyst
Jennifer Simoes, Chief of Legislation
Cheryl Thompson, Licensing Analyst
See Vang, Business Services Analyst
Kerrie Webb, Legal Counsel
Curtis Worden, Chief of Licensing

Members of the Audience:
Bruce Ackerman, Midwives Alliance of North America

AnneMarie Adams, M.D., California Association of Midwives
Lacy Bauer
Kayti Buehler, L.M., California Association of Midwives
Yvonne Choong, California Medical Association
Caroline Cusenza, California Association of Midwives
Kim Dau, C.N.M., Health Policy Chair, California Nurse-Midwives Association
Rosanna Davis, L.M., CPM, California Association of Midwives
Sarah Davis, California Association of Midwives
Jocelyn Dugan, California Association of Midwives
Rachel Fox-Tierney
Faith Gibson, L.M., California College of Midwives
Laurie Gregg, M.D., American Congress of Obstetricians and Gynecologists
Renee Hanevold, California Association of Midwives
Diane Holzen, L.M.
Jessica Johnson, L.M.
Rebekah Lake, California Association of Midwives
Tracy Lough, California Association of Midwives
Treesa McLean, California Family for Access to Midwives
Laura Perez, California Association of Midwives
Constance Rock, California Association of Midwives
Kim Stanford, California Association of Midwives
Sunshine Tomlin, California Association of Midwives
Linda Walsh, CNM, California Nurse-Midwives Association
Brian Clifford, Department of Consumer Affairs
(The above list identifies attendees who signed the meeting sign-in sheet.)

Agenda Item 2 Public Comments on Items not on the Agenda
No comments were provided.

Agenda Item 3 Approval of the December 5, 2013 Midwifery Advisory Council Meeting Minutes
Ms. Ehrlich requested an amendment be made to page five of the minutes, paragraph five, the sentence "Ms. Ehrlich also stated that the challenge mechanism was stringent and included the submittal of charts, and having them read by a certified nurse midwife and a physician, as well as having to take a series of clinical and skills exams." Ms. Ehrlich requested the sentence be reflected as "Ms. Ehrlich also stated that the challenge mechanism was stringent and included the submittal of charts, and having them read by a certified nurse-midwife, or a licensed midwife, and a physician, as well as having to take a series of clinical and skills exams."

Ms. Sparrevohn requested changes be made to page two of the minutes, paragraphs three, four, and eight, as well as page three of the minutes, paragraph two, to strike SB 304 and replace with AB 1308.

Ms. Sparrevohn stated that on page 13 of the minutes, paragraph 11, the sentence "It is a public safety issue if you have a mother and a baby who needs attention at the same time, as two sets of hands may be needed." should be reflected as "It is a public safety issue if you have a mother and a baby who both need attention at the same time, as two sets of hands may be needed."

Ms. Webb agreed that the additional text would be added to the final minutes in brackets as the minutes provided were verbatim.

Ms. Sparrevohn provided additional edits on page 14 of the minutes, paragraph three, that "licensee" should be corrected to "license" and "Bowand" should be corrected to "Bowland".

It was mutually agreed that future meeting minutes would be reviewed by the Chair prior to inclusion into the MAC packets.

Ms. Sparrevohn asked for public comment.

Ms. Sarah Davis commented that there was a reference to Ms. Davis in the minutes and wanted to clarify that it was Rosanna Davis who had made the comments.

Ms. Sparrevohn made a motion to accept the December 5, 2013 minutes with edits; s/Yaroslavsky. Motion carried.

Agenda Item 4 Report from the Midwifery Advisory Council

Ms. Sparrevohn commented that there was ample work to be done, both within the MAC and the Board, to bring about the changes dictated by the new law, while creating an atmosphere of respect and mutual collaboration between the disciplines of medicine and midwifery. With the removal of physician supervision from the licensed midwifery practice act, along with other important changes brought by the passage of Assembly Bill 1308 (AB 1308), there were now new opportunities for creating relationships between physicians and midwives, to bring potential benefits to the birthing families of California.

Ms. Sparrevohn stated that she hoped the new relationships forged between midwives, physicians, and hospitals, would be one of mutual respect with the common commitment to the creation of safety and respectful health care venues and policies for California's women and families. She asked that all licensed midwives throughout the state, work within the provisions of the law to make the changes that will benefit the birthing families in California, and to recognize that the actions of any one midwife would reflect on all midwives.

Ms. Sparrevohn encouraged licensed midwives to work hard in their communities to provide help to unlicensed midwives to prepare them to become licensed; to consider their abilities to precept students in their areas; to work to create networks with their community care providers who will provide options to women that are often difficult to obtain; to work with consumer based organizations such as California Families for Access to Midwives (CFAM) and International Cesarean Awareness Network, to legislate changes to current law where it is necessary and desired by women; and to share the networking and relationship building skills they have developed in their communities, through their state organization (California Association of Midwives (CAM)), in workshops, peer review groups, and online blogs, and in any other way they can think of so that the midwifery community can gain insight into how new pathways for interactions between the professions of midwifery and medicine can be created.

Ms. Sparrevohn asked for public comment. No comments were provided.

Agenda Item 5 Midwifery Assistants Taskforce

Ms. Sparrevohn stated that in order for midwifery assistants to be allowed by law, legislative language must be drafted in order to authorize it. Ms. Sparrevohn appointed a task force that included herself and Dr. Byrne, to review the options, and create a legislative proposal. Language would be presented to the MAC at the August 2014 meeting for discussion.

Ms. Sparrevohn asked for public comment. No comments were provided.

Agenda Item 6 Update on New Board Member Packet

Ms. Sparrevohn referred to a chart provided as a handout at the meeting, which compared the scope of practice for licensed midwives and certified nurse midwives. Ms. Sparrevohn stated that the final version of the chart would be provided as a handout to new board members for informational purposes. Ms. Sparrevohn commented that the chart had been created as most health care providers were familiar with the scope of practice for certified nurse midwives, but less familiar with the scope of practice for licensed midwives.

Ms. Ehrlich requested the item be added to the next meeting agenda in order to allow sufficient time to review the chart that had been provided.

Ms. Sparrevohn asked for public comment. No comments were provided.

Agenda Item 7 Midwives Alliance of North America (MANA) Statistical Reporting Comparison

Ms. Ehrlich stated that the agenda item had been incorrectly titled and should have reflected, "Licensed Midwives Annual Report (LMAR) Statistical Reporting Comparison." Ms. Ehrlich referred to the summary and charts included in the meeting materials and stated that the documentation provided was a summary of the six years that the annual reporting had been completed through the Office of Statewide Health Planning and Development (OSHPD). Ms. Ehrlich indicated that she had compiled the statistics in order to provide an overview of the data submitted during that timeframe, so that further discussion could be had to determine what changes might be made to insure viable and accurate data was being obtained. Ms. Ehrlich felt that one area of the report that needed to be addressed were the references to fetal demise. During her review of the reporting instructions and the statistics, she found that fetal deaths were categorized on the report as "from 20 weeks through labor," and felt that it should be better defined. She stated that more information was needed to understand fetal deaths up to the onset of labor, fetal deaths during labor through to the immediate neonatal period, and neonatal deaths following the immediate neonatal period. Ms. Ehrlich recommended that the fetal deaths data element be clearly defined in those categories.

Ms. Ehrlich referred to the chart stating that the statistics did not calculate for fetal demise diagnoses prior to labor, fetal demise diagnoses during labor or at delivery, and live born infants who subsequently died.

Ms. Ehrlich discussed possible enhancements that could be made to the electronic reporting system, suggesting that when data was entered in Section E of the report "Outcomes Per County in Which Birth, Fetal Demise, or Infant or Maternal Death Occurred," additional questions could be prompted, asking how many births had been completed, how many fetal demises, and how many maternal

deaths. The midwife would be required to explain exact gestational age, if it was prior to labor, and the reason for the death if it was known. Providing the data in this format would ensure that data would not be entered multiple times and would provide more accurate statistics.

Ms. Lowe responded that making updates to the reporting requirements would require regulation changes. She also stated that Board staff has the ability to edit the form to add clarifying text regarding the data needed to be entered, and that Board staff would discuss the options of adding prompting fields with the Board's Information Systems Branch to determine if this would be an option.

Ms. Sparrevohn suggested that Ms. Ehrlich be present when discussing the enhancements with Board staff since she is familiar with where the discrepancies are located.

Ms. Sparrevohn questioned if changes to the regulation would be required.

Ms. Webb responded that a change to the regulation would provide clarification, and if data elements were to be added or deleted it would require a statutory change.

Ms. Dobbs agreed that if clarifiers are added then it must be in line with the statute, and with any existing regulation.

Ms. Yaroslavsky asked for clarification on the statistics that will be gathered for fetal demises; whether they should be obtained prior to labor or at the end of the delivery.

Ms. Sparrevohn responded that the statistics would be gathered at the end of pregnancy, before labor starts.

Ms. Marceline suggested having an individual who has never completed the LMAR, and is not familiar with computers, be given the job of testing.

Mr. Ackerman stated that his agency, Midwives Alliance of North America (MANA), gathers data and provided insight regarding their process. His agency has a trained team of individuals who interview a midwife whenever a report reflects a demise other than a miscarriage. The software used, has a large number of useful functions available. For example, if a Cesarean-section was reported, but the place of birth was at home, the system would raise a flag for the midwife. The midwife would be expected to either explain the flag or correct it. The data reviewer would contact the midwife and inquire if there was an explanation regarding the occurrence. Their system requires a combination of software and human interaction to obtain accurate data.

Ms. Sparrevohn asked Ms. Lowe if there was a timeframe for when the work group would meet to discuss the reporting format.

Ms. Lowe responded that she anticipated the issue being raised prior to the next MAC Meeting.

Ms. Sparrevohn asked if there were additional comments from MAC members or the public on the agenda item.

Ms. Ehrlich stated that she had additional comments regarding the LMAR results, specifically the reasons for hospital transfers. She stated that most midwives wrote in the reason for why they transferred a mother and/or a baby; however, after reviewing the numbers, they were not consistent with the other numbers in the same category.

Ms. Ehrlich commented that the overall summary of the outcomes of planned out-of-hospital births with licensed midwives appeared consistent. The percentages of births that were completed out-of-hospital ranged between 81% and 85%, the percentages of intrapartum transfers over those years ranged between 17% and 20%, and the percentages of newborn transfers ranged between 2% and 2.6%, reflecting consistent data.

Ms. Sparrevohn asked if there were any other comments from the MAC or the public. No further comments were provided.

Agenda Item 8A Transfer of Planned Out-of-Hospital Reporting Form

Ms. Lowe referenced the Transfer of Planned Out-of-Hospital Delivery to Hospital Reporting Form which was included in the meeting materials, stating that pursuant to the changes made by AB 1308, Business and Professions Code Section (B&P) 2510 was added, requiring the Board to create a form that would be utilized by hospitals for reporting each transfer of a planned out-of-hospital birth. Prior to finalizing the form, input was obtained from outside sources, including CAM, American Congress of Obstetricians and Gynecologists (ACOG), California Medical Association (CMA), California Hospital Association (CHA), and other hospitals within the state. Feedback that was obtained included requests for additional data elements to be reported, as well as to change the wording "Health Care Provider" to "Physician." Because the form was created without regulations in place, the Board was only able to request items on the form to meet the existing law. Ms. Lowe continued to explain that in order to add additional data elements the Board would need to begin the regulatory process. The form that was provided was the finalized version that would be posted to the Board's website, and would be sent to California hospitals.

Ms. Ehrlich questioned who had finalized the document.

Ms. Lowe responded that the form had been created by Board staff and legal counsel, and was then provided to the outside agencies mentioned previously for additional input.

Ms. Ehrlich stated that it was interesting to see that the name of the mother was not on the form.

Ms. Lowe clarified that the form was separated into two different documents, only listing the mother's name on the second page of the document, as the mother's name was not to be provided to the California Maternal Quality Care Collaborative (CMQCC).

Ms. Sparrevohn asked for public comment.

Ms. Sarah Davis referenced a statement that was provided by Ms. Lowe, "only data elements that are in statute could be on the form" and inquired about the check box for "Licensed Midwife Arrived with Patient" which was not in statute. Ms. Davis questioned if there was a benefit of having it on the form considering that it was not in statute. Ms. Davis stated that she was not necessarily opposed to it, but was only reflecting what Ms. Lowe had stated earlier.

Ms. Webb responded that the statement "the Licensed Midwife shall provide records, including prenatal records, and speak with the receiving physician and surgeon" was a way of verifying how the information was gathered.

Ms. Sarah Davis continued to refer to what was mentioned by Ms. Lowe indicating that the statute did not require the midwife to arrive with the patient, and questioned if the statement should be on the form.

Ms. Yaroslavsky commented that if a report was filed and indicated further review was necessary, much more information and data would be necessary to determine if the incident had relevance or not. Information could not be acquired if the Board did not have the name of a person and did not know the circumstances.

Ms. Sarah Davis clarified that it was required by statute that the licensed midwife call to report the transfer, and it was required that she provide the medical records; however, it was not required that she arrive with the patient, and wanted clarification that the information would not be used punitively.

Ms. Sparrevohn questioned if there was a process to track the physician who took the report from the midwife, stating that she felt it would be a valuable piece of information.

Ms. Kirchmeyer agreed to include the physician's name, if different from the individual who was assuming care, and to include the type of license that the individual held.

Ms. Ehrlich suggested adding a statement on the form, where the mother's name appears, to read "This page should only be sent to the Medical Board California. Do not include it in the report that goes to the CMQCC."

Ms. Kirchmeyer agreed to add a statement reflecting Ms. Ehrlich's request on the second page of the form.

Ms. Marceline questioned if the transferring midwife would need to alert the patient that their name would be provided to the Board when entering the hospital and felt there may be concerns with privacy issues.

Ms. Sparrevohn stated that the patient's name would be used as a way to gather additional information about the transfer, in order to review what, if anything, went wrong, and how improvements could be made. Ms. Sparrevohn stated that the process could not be completed if the patient's name was unknown.

Dr. Gregg commented that she felt the form was a fine first attempt for what was needed, but suggested creating a working group to determine the requirements necessary to fulfill the legislative intent of the form.

Ms. Sparrevohn stated that it would be beneficial to move forward with an Interested Parties Meeting for the form, where ideas could be presented and discussed. Following the Interested Parties Meeting, regulations could be crafted.

Faith Gibson commented that she had recently had an emergent transfer and had provided the patient records at the hospital; however, copies were not made. She also stated that in at least three instances, the physician did not want to discuss the patient transfer. Both issues indicated that there were issues present relating to communication while transferring a patient. Ms. Gibson suggested that the name of the midwife only be included on the second page of the form so that the information provided to CMQCC would only contain the statistical information about the births. She also questioned what access the midwife would have to obtain a copy of the filed report.

Ms. Sparrevohn suggested that the Board correct the form to protect the confidentiality of the healthcare provider assuming care, the licensed midwife, and the patient receiving care, and agreed that the form should have all the names on the second page so that they would not be provided to CMQCC.

Ms. Webb responded to Ms. Gibson's question relating to the midwife's access to the filed report, stating that a midwife would be entitled to information either by a summary or via copy of the actual form, in order to review the statements made regarding their care, pursuant to the "Information Practices Act."

Ms. Marceline questioned if the Board would provide a copy of the reporting form if requested by the midwife in order to check for accuracy.

Ms. Webb stated that B&P 800(c) outlined options for obtaining information from the Board's central files if requested by a licensee. The Board would not be required to provide an actual copy of the report but could instead provide a summary.

Ms. Rosanna Davis commented that she had completed transfers since the first of the year, and that it had been extremely helpful during a transfer, to inform the receiving care providers that she was required to speak to the physician, and that it had improved communication immensely.

Dr. Gregg commented that it was extremely important that it be known that the physician was the provider who was ultimately responsible for the patient, even though it may be a certified nurse midwife that would be taking over care. Dr. Gregg also stated that midwives who have carried a copy of the law with them have been successful in speaking with the physician and have been able to provide a copy of the records. In the working group Dr. Gregg participated in, it was a hospital to Board and CMQCC form. The hope was that the Board could use the information for peer review. Dr. Gregg stated that hospitals peer review their own documents, and suggested the Board take advantage of the available data.

Ms. Sparrevohn suggested adding check boxes to the form for the most common reasons for hospital transfers instead of providing the information in a narrative format as it was currently.

Ms. Hanevold commented that she thought the intent of the form was to improve communication and collaboration between providers, and that if a midwife or a transferring midwife was not included in the process it was not reflecting the true nature of what was intended.

Ms. Sparrevohn stated that it was going to be an evolving process as the law was written requiring the hospital to submit the form, and felt that as things evolved and relationships were created

between licensed midwives, physicians, and hospitals, the midwives' input would be given.

Ms. Yaroslavsky commented that the object of the form was to advance the midwifery profession, and that after a certain amount of time, a review of the findings would be conducted. The outcome of the form would be to make the process more efficient for everyone, regardless of title, and that everyone would be working together in collaborative perspectives. Ms. Yaroslavsky encouraged all interested parties to participate.

Ms. Sparrevohn asked if there were any other comments from the MAC or public. No further comments were provided.

Agenda Item 8B Practice Guidelines for California Licensed Midwives

Ms. Lowe stated that pursuant to AB 1308, B&P 2507(f), which authorized the Standard of Care for California Licensed Midwives (Standard of Care), was removed from law. Ms. Lowe referred to the newly created Guidelines for California Licensed Midwives (Guidelines) document which was included in the meeting materials. Ms. Lowe stated that the Standard of Care document was updated in order to be in compliance with the requirements of AB 1308. Ms. Lowe requested the MAC approve the Guidelines for recommendation to the Full Board at the May 2014 Quarterly Board Meeting.

Ms. Yaroslavsky commented that she had read the Guidelines from a non-medical perspective, and more so as a legal document, and that terms like "rationality" did not sit right with her and that she would rather see other wording like "evidence based," "appropriately," or "effective." She also recommend changing the statement on page two of the Guidelines, letter C, "licensed midwife provides care in private hospital" to reflect "California licensed midwife may provide care in appropriate locations."

Ms. Lowe stated that the only changes that had been made to the Standard of Care document were those required by AB 1308. If additional changes, outside of those made pursuant to the law change, were being requested, additional feedback from the MAC and the midwifery community would be necessary in order to ensure all suggestions were being taken into consideration. At this time, since the Guidelines only touched on those directly affected by the law change, and there was no Standard of Care in place at the time, Board staff recommended moving forward with the document as provided in the meeting materials.

Ms. Sparrevohn stated that it was her understanding that the entire Guidelines document would be reviewed during the meeting, then an Interested Parties Meeting would take place, and lastly it would be presented as a regulation change at the October 2014 Quarterly Board Meeting.

Ms. Webb responded that it would not go through the regulatory process because it was a practice guideline, similar to the prescribing guidelines for physicians, and that the changes would not require a regulation change, as it was taking what was put into the Standard of Care document and keeping it as something that was still viable for the community.

Ms. Sparrevohn requested clarification of the changes in the Guidelines that contained strikeouts and underlines.

Ms. Kirchmeyer clarified that the guidelines that did not contain strikeouts were the current requirements outlined in statute. The guidelines that did contain strikeouts were previously required pursuant to B&P 2507(f), which had been removed pursuant to AB 1308. Ms. Kirchmeyer stated that there was no longer regulatory authority for the Standard of Care document because the section of law had been removed, and that in order to assist the midwifery community, the Board wanted to provide information to the public that would be in compliance with the law. B&P 2507(b)(1)(a)(i) would still need to go through the regulatory process, to define "normal pregnancy."

Ms. Sparrevohn asked if there was a list that currently existed which defined "normal pregnancy."

Ms. Kirchmeyer responded that a list did not exist, and was hopeful that language could be drafted and presented at an Interested Parties Meeting; however, since that had not yet happened it was necessary to provide guidance to the midwives. The Guidelines would need to be approved by the MAC so that they may be presented to the Full Board for approval. Once approved, they would then be placed on the Board's website as the Guidelines, and not as the Standard of Care document that was previously required in regulation.

Ms. Sparrevohn stated that since there was no regulation that dictated when midwives would have to transfer, or what to consult for specifically, that the licensed midwives would need to refer to the Guidelines.

Ms. Kirchmeyer confirmed that was the reason why it was so important to have the Guidelines in place.

Ms. Sparrevohn commented that the list to define "normal pregnancy" should include consult for cardiac disease, pulmonary disease, and those types of subjects. Ms. Sparrevohn stated that many midwives will question what the list contains since there was no longer the Standard of Care document.

Ms. Kirchmeyer requested the MAC, CAM, ACOG, provide any edits they may have relating to the Guidelines to Board staff.

Ms. Dobbs added that the only edits that were being solicited during the meeting were the items that had been added and/or deleted.

Ms. Sparrevohn stated that she had reviewed the Guidelines and requested a change be made on page three, to the first paragraph, which states in part: "Practice-specific guidelines and protocols are customarily implemented through standard or customized chart forms, informed consent and informed refusal documents..." Ms. Sparrevohn requested "informed refusal documents" and "treatment waivers" should be retained as the issue may not be that a woman was refusing to go to a physician when informed to go, but that it could be she did not want to have an HIV test, or want her child to have vitamin K after birth. In these situations, the patient would give the doctor an informed refusal for the HIV test or treatment. Ms. Sparrevohn requested that the language remain the same as it was not a reference to the woman being able to refuse. She requested the same be referenced on page four, number ten of the Guidelines.

Ms. Webb agreed with the change as long as it stated in brackets that it did not include a waiver of

referral to physician in required circumstances.

Ms. Sparrevohn also commented that on page eight of the Guidelines, the first line stating "Healthy mother without serious pre-existing medical or mental conditions" should remain, as the criteria for initial selection assumes that the patient is a healthy mother, without serious pre-existing medical or mental conditions.

Ms. Sparrevohn also commented that there were inconsistencies in language throughout the Guidelines on whom the patient would need to be referred to, as on page nine of the Guidelines, letter A, it states "a licensed physician who has current training and practice in obstetrics and gynecology," and in other places it states "physician and surgeon." Ms. Sparrevohn requested clarification of the language.

Ms. Sarah Davis commented that the "training in obstetrics and gynecology" was used where that specific physician would be determining if the pregnancy was normal, so that the client could continue care with the licensed midwife. Any physician making that assessment to allow the midwife to continue client care would have to be a physician with that training.

Dr. Gregg stated that the intention was that all references of referral would be to a licensed physician who has current training and practice in obstetrics and gynecology.

Ms. Rock commented that there are rural areas within California where the physician providing obstetrics are family practice doctors and that there may not be an obstetrician at the local hospital.

Ms. Sparrevohn stated that on page ten of the Guidelines "labor and birth outside of a hospital" should be changed to "licensed midwife attended care" or to "returned to the licensed midwife's care" so that it is clear that the midwife would manage the remainder of the care. Also, on page 12 of the Guidelines, letter A "Referral does not preclude the possibility of a domiciliary labor and birth outside of a hospital" should be changed to "referral does not preclude the possibility of a midwife attended labor and birth." On page 11 of the Guidelines, letters Q and R, where it states "before the completion of the 37 0/7 completed pregnancy weeks of pregnancy" should be changed to " 37 0/7 completed weeks of pregnancy." On page13 of the Guidelines, letter D, "The California licensed midwife provides records, including prenatal records, and consults with the receiving physicians about labor up to the point of transfer to a hospital" should state "about care up to the point of transfer to a hospital" rather than "about labor" as it could be after labor has finished, and the baby has already been born, or could be prior to labor.

Ms. Webb responded that the statement was based on B&P 2510, which states in part "If a client is transferred to a hospital, the licensed midwife shall provide records, including prenatal records, and speak with the receiving physician and surgeon about labor up to the point of the transfer."

Ms. Marceline was concerned with inconsistencies throughout the document relating to a client's right to self-determination, as the option had been stricken on page nine of the Guidelines, letter B; however, on page one of the Guidelines it states a need for a code of ethics and informed consent policies, and on page two of the Guidelines it states the licensed midwife's fundamental accountability is to the woman in her care, and on page six of the Guidelines it states in part "The licensed midwife respects the autonomy of the mentally competent adult woman." Ms. Marceline

commented that all of those statements should be struck since the client's right to self-determination was being removed.

Ms. Sparrevohn commented that the intention was to make it clear that midwives could not continue with that type of care, and that midwives need to respect the women's autonomy but must also meet the confines of the license. The solution being to modify page nine of the Guidelines, letter B, to make it clear that the client retains the right of informed refusal, in that she can refuse the referral to a physician or hospital, but that the midwife would not be able to continue care for the client after that point.

Ms. Ehrlich commented that it could be considered patient abandonment if there was no time to enlist another care provider.

Ms. Sparrevohn asked if Dr. Gregg could provide input on what the process is, in a hospital setting, when a patient refuses the advice or care of the provider.

Dr. Gregg responded that the physicians practice within their respective specialty areas and confines of their license. The only rare case would be the Good Samaritan Rule.

Ms. Sparrevohn questioned what a woman's options would be if there was no one that would provide the care that the woman was requesting.

Dr. Gregg responded that the patient trusts the caregiver and that the caregiver can guide and assist the patient to make good decisions in most cases.

Ms. Gibson commented that Christian Scientist women have treatment waivers, and informed consent, relative to doing normal routine blood work. Such issues have nothing to with whether or not a woman is post 42 weeks, the baby is breech, or the like. Those types of situations would still need to be considered and the choices respected.

Ms. Sarah Davis stated that CAM was in support of the Guidelines with the edits from staff, and Ms. Sparrevohn. Ms. Davis stated that the issue of client autonomy was important to CAM, and to all the other stakeholders.

Ms. Webb stated that all comments had been noted and that a short recess would be necessary to review the information obtained and to make appropriate edits to the document.

Following the recess, Ms. Webb confirmed that the following changes would be made to the Guidelines:

- On page three of the Guidelines, letter H, "and informed refusal" would remain in place; "and treatment waivers" would be struck;
- On page four of the Guidelines, number ten, "and informed refusal" would remain in place; "and treatment waivers" would be struck;
- On page eight of the Guidelines, "Healthy mother without serious pre-existing medical or mental conditions" would remain; "including, but not limited to:" would be added following "History, physician assessment and laboratory results within limits commonly accepted as normal and consistent with B&P 2507 (b)(1) with no clinically significant evidence of the

following";

- On page nine of the Guidelines, a paragraph would be added that states: "It is recognized that the client has the right to refuse the recommended referral; however, pursuant to the law, the Licensed Midwife cannot continue care. The Licensed Midwife will document refusal of the referral in the client's record.";
- On page ten of the Guidelines, "domiciliary care" would be struck and replaced with "care with a licensed midwife"; "labor and birth outside of a hospital" would be struck and the sentence would read as "A referral for immediate medical care does not preclude the possibility of care with a licensed midwife, if a physician who has current training in…";
- On page 11 of the Guidelines, letter Q, the first word "pregnancy" would be struck;
- On page 11 of the Guidelines, letter R, the first words "weeks of" would be struck;
- On page 12 of the Guidelines, letter A, would reflect "referral does not preclude the possibility of return to care with a licensed midwife"; "labor and birth outside of the hospital" would be struck; and
- On page 13 of the Guidelines, letter D, would remain the same.

Ms. Sparrevohn asked for any additional public comments. No further comments were provided.

Ms. Sparrevohn made a motion to accept the edits in the language and to recommend to the Full Board for approval; s/Webster. Motion carried.

Agenda Item 8C Pathway for Certified Nurse Midwives to Become Licensed Midwives

Ms. Lowe stated that at past MAC meetings, the idea of approving Certified Nurse Midwife (CNM) education programs, as well as the idea of allowing CNM licensure as a viable method of applying for a Licensed Midwife (LM) license had been discussed. The Board reviewed the ideas and was interested in obtaining additional information from outside sources to determine the viability of the options. Currently, the Board would be more inclined to pursue the option of CNM licensure as a pathway, versus approving CNM education programs, as education would require each program to go through the education provider approval process which can be a lengthy process involving multiple schools. Ms. Lowe stated she had requested information from the American College of Nurse-Midwives (ACNW), and will be in contact with the Board of Registered Nursing (BRN), and with the California Nurse-Midwives Association (CNMA) to gather more information on the idea. Once information is obtained, staff will review and provide an update at the next MAC meeting.

Ms. Sparrevohn asked if a CNM was licensed in any state if they would be able to request reciprocity for a LM license in California.

Ms. Lowe stated that it may be an option, but in order to determine that, the Board would need to request documentation from CNMA to compare the standards across the United States with California's.

Ms. Sparrevohn asked for public comment.

Ms. Dau introduced herself as the Health Policy Chair for CNMA and commented that their primary policy agenda at CNMA was to remove the supervision requirements for CNMs. However, as the out-of-hospital CNMs were finding it difficult to find willing supervising physicians they were interested in the option of having a CNM to LM pathway. Ms. Dau expressed concern with licensees

holding dual licenses and stated that clarification would be needed from both BRN and MBC on what the expectations would be for those individuals.

Ms. Dau stated that CNMA did not have a bill this year regarding CNM supervision requirements, and that they would be continuing to discuss the issue. Ms. Dau indicated that she is interested in making sure that CNMs who provide out-of-hospital care to their clients, can continue to do that legally.

Ms. Sparrevohn asked for any additional public comments. No additional comments were provided.

Agenda Item 8D Possible Revisions to Licensed Midwife Annual Report (LMAR)
Ms. Lowe recommended that a task force be established to review the current data elements required on the Licensed Midwife Annual Report (LMAR) to determine if enhancements to the report and the formatting would be beneficial.

Ms. Sparrevohn appointed Ms. Ehrlich and herself to the task force.

Ms. Sparrevohn asked for public comment. No comments were provided.

Agenda Item 8E Challenge Mechanism Changes
Ms. Lowe provided an update on the challenge mechanism, stating that pursuant to AB 1308, B&P 2513(a) was added, which states: "Beginning January 1, 2015, new licensees shall not substitute clinical experience for formal didactic education." Ms. Lowe stated that concern had been raised as to whether the addition would eliminate the challenge mechanism all together, and if so, what the options would be for midwives who did not meet the formal education requirements; as well as that there had been confusion on what elements would still be able to be challenged.

Ms. Lowe informed the MAC that staff and legal counsel had reviewed the issues and that the Board's stance on the law was that clinical experience could be challenged to clinical experience and didactic to didactic; however, clinical experience could not be used to challenge didactic requirements. The determination of whether or not the didactic education would satisfy the requirements in law would be left to the approved challenge mechanism providers to determine if it met the California requirements.

Ms. Sparrevohn confirmed that the challenge mechanism would remain intact and would now have an additional requirement that the individual prove that they have had formal didactic education.

Ms. Lowe confirmed that Board staff would be in contact with the challenge programs to ensure that they could meet the California requirements.

Ms. Sparrevohn asked for public comment. No comments were provided.

Agenda Item 8F Findings from Survey Regarding Impact of Implementation of AB 1308 Pertaining to Practice of Midwifery: Drugs and Devices
Ms. Lowe stated that at the December 2013 MAC meeting, it was requested that feedback be obtained from the midwifery community regarding their experience in obtaining lab accounts, supplies and devices following the implementation of AB 1308. A survey was generated by Board

staff and with the assistance of CAM, was sent by email to all CAM members. The results of the survey were provided in the meeting materials and reflected that 48 individuals had participated in the survey.

Ms. Lowe briefly went over the findings, stating that the majority of the written comments that were provided indicated that midwives were not having difficulties after implementation of the law, and also indicated that they had not experienced issues prior to the law. Ms. Lowe stated that the midwives were thankful that the requirements were now in law, but that the questions raised in the survey did not seem like an issue to the midwifery community.

Ms. Lowe stated that based on the results of the survey and the short amount of time since the changes were implemented, a follow-up survey would be sent to licensed midwives prior to the December MAC meeting. The follow-up survey would allow enough time from the implementation of the law to determine how the process was working and if any additional changes were necessary.

Ms. Sparrevohn asked for public comment. No comments were provided.

Agenda Item 8G Regulatory Update

Ms. Lowe stated that several items in law and regulation would require interested parties meetings in order to draft new language. Several regulations would also require Section 100 changes that would clean up the existing language pursuant to the new laws. Interested parties meetings would be held prior to the next MAC meeting in order to obtain feedback on several items, including: data elements provided on the Transfer Reporting Form, data elements to be collected for the LMAR, and also regarding B&P 2507 (b)(1)(A)(i), which would need further definition. Following the meetings, staff would begin the process of drafting language for approval.

Staff would also be drafting language for California Code of Regulations (CCR) Section 1379.15, which would need to conform to the changes made to the challenge mechanism. CCR 1379.31 would also require changes once staff is able to determine if a certified nurse midwife license would be considered a viable method of applying as a licensed midwife.

Ms. Lowe stated she is hopeful to bring drafted language back to MAC so that it can be presented to the Full Board in October. Staff would be working diligently to get the interested parties meetings completed as well as to draft language to provide to the MAC in August.

Ms. Sparrevohn asked for public comment. No further comments were provided.

Agenda Item 9 Program Update

Ms. Lowe stated that the Midwifery Analyst vacancy for the Board had been filled by Ms. AnnaMarie Sewell. Ms. Sewell will be handling the midwifery desk, which is also responsible for handling the Outpatient Surgery Settings Program, Research Psychoanalyst Program, and overseeing the Polysomnography Program for the Board.

Agenda Item 9A Breeze Update

Ms. Lowe provided an update on BreEZe, the Department of Consumer Affairs' Online Licensing System, used for internal processing of applications, renewals, issuing licenses, as well as an online site for consumers to verify licenses and to file complaints. Ms. Lowe stated that the midwifery

initial application was not currently available to be completed online, nor was the online renewal. The two transactions are slated to be released in August of this year; however, prior to being released, staff will be responsible for testing the applications to ensure they meet the Board's requirements.

Ms. Sparrevohn questioned if there were still issues with the renewals being processed through BreEZe.

Ms. Lowe explained that there are two sides of the BreEZe system: Versa Online (VO), which is the online system, and Versa Regulation (VR), which is the internal system. The Board is using the internal system to process renewals, generate renewal forms, and to generate renewal deficiency letters. The online renewal transaction that will allow the licensee to pay online is not yet available. Ms. Lowe indicated that there have been some improvements to the system; however, as staff continues to utilize the system, new concerns are still being reported to the Department. Staff is working with the Department and the vendor to come to a solution on how the Board's issues can be resolved. It is a very time consuming process but will make for a better system for the future.

Agenda Item 9B Licensing Statistics

Ms. Lowe began by stating that the documentation provided in the meeting materials contained an error, in that the fiscal year had not been updated to reflect the second quarter's information. The information had since been corrected and updated copies were provided to the MAC and to the public.

Ms. Lowe stated that there was still an inability to obtain statistical information using the BreEZe system, and that although reports had been created, the information could not be relied upon. Currently, staff was in the process of correcting the reports and was hopeful that they could be finalized by the next MAC meeting. Ms. Lowe added that the statistics that had been provided in the materials were those that could be manually calculated.

Agenda Item 9C Enforcement Statistics

Ms. Lowe stated that due to the inability to obtain statistics from the BreEZe system, no enforcement statistics were available to provide. Ms. Lowe stated that she was hopeful to have the statistics available at the next MAC meeting.

Agenda Item 9D NARM Exam

Ms. Lowe provided a brief update on the National Association of Registered Midwives (NARM) exam, stating that the Board had proctored an exam in early February and that there were three applicants who had sat for the exam. Ms. Lowe also stated that she had obtained information from NARM that they anticipated moving to an online examination system by the end of the summer and that the Board would no longer be responsible for proctoring the exams.

Ms. Sparrevohn asked for public comment. No comments were provided.

Agenda Item 10 Agenda Items for the August 14, 2014 Midwifery Advisory Council Meeting

The following agenda items were identified by Ms. Sparrevohn for the August 14, 2014 MAC meeting:

- Midwifery Program Update
- Report from the MAC Chair
- Practice Guidelines for California Licensed Midwives Update
- Midwifery Assistants Task Force Update
- LMAR Data Points Task Force Update
- Regulatory Changes Update
- New Board Member Packet Update

Ms. Sparrevohn asked for public comment. No comments were provided.

Agenda Item 11 Adjournment
Ms. Sparrevohn adjourned the meeting at 4:27 p.m.

The full meeting can be viewed at www.mbc.ca.gov/board/meetings/Index.html