MEDICAL BOARD OF CALIFORNIA - 2020 TRACKER LIST
April 24, 2020

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 890	Wood	Nurse practitioners: scope of practice: practice without standardized procedures	Senate Committee BP&ED	Oppose (May 2019)	1/23/20
AB 2239	Maienschein	Health care: physician loan repayment	Assembly Health Committee	Reco: Support	3/12/20
AB 2273	Bloom	Approvals and certificates of registration: special faculty permits	Assembly Health Committee	-	-
AB 2478	Carrillo	International medical graduates: study	Assembly Committee B&P	Reco: Oppose	-
SB 1237	Dodd	Nurse-midwives: scope of practice	Senate Committee BP&ED	-	-

Blue – For Discussion

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER:	AB 890
AUTHOR:	Wood
BILL DATE:	January 23, 2020, Amended
SUBJECT:	Nurse practitioners: scope of practice: practice without standardized procedures
SPONSOR:	Author
POSITION:	Oppose (May 2019 Board Meeting)

The purpose of this bill is to authorize a nurse practitioner (NP) to practice without physician supervision in specified health settings that have controls and processes in place. This bill would also allow NPs to practice without physician supervision outside of those settings if they complete a "transition to practice program." In both settings, NPs would be subject to the same consumer protection measures as physicians, such as peer review and the ban on the corporate practice of medicine. In the past, the Board has opposed bills that remove physician supervision for NPs and allowed independent practice. Although this bill includes more oversight mechanisms than past proposed legislation, the Board continues to have concerns with allowing NPs to practice without physician supervision. The Board took an oppose positon on the bill at the May 2019 Quarterly Board Meeting. The bill was amended January 23, 2020.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would create the Advanced Practice Registered Nursing Board (APRNB) within the Department of Consumer Affairs (DCA). This bill would require the board, by regulation, to define minimum standards for a nurse practitioner (NP) to transition to practice without the routine presence of a physician and surgeon. The will would authorize an NP who meets certain education, experience, and certification requirements to perform, in certain settings or organizations, specified functions without standardized procedures. This bill would authorize an NP to perform those functions without standardized procedures outside of specified settings or organizations in accordance with specified conditions and requirements if the nurse practitioner holds an active certification issued by the APRNB. The bill would also require the APRNB to request the department's Office of Professional Examination Services, or an equivalent organization, to perform an occupational analysis of nurse practitioners performing certain functions. The bill would require the APRNB to take specified measures to identify and assess competencies. The bill would require the APRNB to identify and develop a supplemental examination for licensees if needed based on the assessment, as provided.

BACKGROUND:

Existing law provides for the regulation and licensure of the practice of nursing by the Board of Registered Nursing (BRN) under the Nursing Practice Act. (Act). Existing law

defines the nursing scope of practice as functions, including basic healthcare, that help people cope with or treat difficulties in daily living that are associated with their actual or potential health or illness problems, and that require a substantial amount of scientific knowledge or technical skill. Existing law includes within the scope of nursing practice all of the following:

- Direct and indirect patient care services that ensure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures.
- Direct and indirect patient care services, including the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist.
- The performance of skin tests, immunization techniques, and the withdrawal of human blood from veins and arteries.
- Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and determination of whether the signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics, and implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with “standardized procedures,” or the initiation of emergency procedures.

Existing law defines “standardized procedures” as either of the following: policies and protocols developed by a licensed health facility through collaboration among administrators and health professionals including physicians and nurses; and policies and protocols developed through collaboration among administrators and health professionals, including physicians and nurses, by an organized health care system that is not a licensed health facility.

Existing law provides for the additional certification of registered nurses as NPs and specifies requirements and conditions of the certification.

Existing law requires applicants for qualification or certification as an NP under California law to meet the following requirements:

- Hold a valid and active registered nursing license.
- Possess a master’s degree in nursing, a master’s degree in a clinical field related to nursing, or a graduate degree in nursing.
- Complete an NP program approved by the BRN.

Existing law authorizes an NP, pursuant to standardized procedures, to do any of the following:

- Order durable medical equipment.
- After performance of a physical examination by the NP and collaboration with a physician and surgeon, certify disability for purposes of unemployment.

- For individuals receiving home health services or personal care services, after consultation with the treating physician and surgeon, approve, sign, modify, or add to a plan of treatment or plan of care.

Existing law allows an NP to furnish or order drugs or devices pursuant to standardized procedures, as specified.

ANALYSIS:

This bill would create the APRNB within DCA, consisting of nine members. This bill would specify that this section shall remain in effect only until January 1, 2026, and as of that date is repealed. This bill would specify that until January 1, 2026, four members of the APRNB shall be licensed registered nurses (RN) who shall be active as NPs and shall be active in the practice of their profession engaged primarily in direct patient care with at least five continuous years of experience. This bill would specify that beginning January 1, 2026, four members of the APRNB shall be NPs licensed under the provisions of this bill. This bill would specify that three members of the APRNB shall be physicians licensed by the Medical Board of California (Board) or the Osteopathic Medical Board of California, at least one of the physician members shall work closely with an NP. This bill would specify that the remaining physician members shall focus on primary care in their practice. This bill would specify that two members of the APRNB shall represent the public at large and shall not be licensed under any board under DCA.

This bill would specify that an NP may perform the functions authorized in this bill if the NP satisfies certain requirements including: holds a certification as an NP from a national certifying body recognized by the APRNB; pass a national NP examination; provides documentation that educational training was consistent with standards established by the Board, as specified; and completes a “transition to practice” program for a minimum of three years of practice or 4600 hours. An NP, who meets all of the requirements and practices in one of the following settings or organizations in which one or more physicians practice with the NP, may practice without standardized procedures:

- A licensed clinic,
- A health facility,
- A county medical facility, or
- A medical group practice, including a professional medical corporation, another form of corporation controlled by physicians, a medical partnership, a medical foundation exempt from licensure, or another lawfully organized group of physicians and surgeons that provides health care services.

This bill would specify that in health care agencies that have governing bodies, the following apply:

- An NP shall adhere to all applicable bylaws.
- An NP shall be eligible to serve on medical staff and hospital committees.
- An NP shall be eligible to attend meetings of the department to which the NP is assigned. An NP shall not vote at department, division, or other meetings unless

the vote is regarding whether a licensee's employment is in the best interest of the communities served, as specified or the votes is allowed by applicable bylaws.

This bill would specify that a facility shall not interfere with, control, or otherwise direct the professional judgment of an NP functioning pursuant to this bill in a manner prohibited by Section 2400 or any other law, subjecting these NPs to the ban on the corporate practice of medicine. This bill would also subject NPs who meet the requirements of this bill to peer review laws in Business and Professions Code Section 805 and 805.5.

In addition to any other practices authorized by law, this bill would specify that an NP who meets the requirements of this bill may perform the following functions without standardized procedures in accordance with their education and training:

- Conduct an advanced assessment.
- Order, perform, and interpret diagnostic procedures.
- Establish primary and differential diagnoses.
- Prescribe, order, administer, dispense, and furnish therapeutic measures, including, but not limited to, the following:
    - Diagnose, prescribe, and institute therapy or referrals of patients to health care agencies, health care providers, and community resources.
    - Prescribe, administer, dispense, and furnish pharmacological agents, including over-the-counter, legend, and controlled substances.
    - Plan and initiate a therapeutic regimen that includes ordering and prescribing non-pharmacological interventions, including, but not limited to, durable medical equipment, medical devices, nutrition, blood and blood products, and diagnostic and supportive services, including, but not limited to, home health care, hospice, and physical and occupational therapy.
- After performing a physical examination, certify disability.
- Delegate tasks to a medical assistant.

This bill would require an NP to inform all new patients in a language understandable to the patient that an NP is not a physician. For purposes of Spanish language speakers, the nurse practitioner shall use the standardized phrase "enfermera especializada."

This bill would require an NP to refer a patient to a physician or other licensed health care provider if a situation or condition of a patient is beyond the scope of the education and training of the NP.

This bill would require an NP practicing under this section to maintain professional liability insurance appropriate for the practice setting.

This bill would specify that the following would apply to an NP who is actively licensed under this article and who holds an active certification issued by the APRNB under this bill:

- The NP may perform the functions authorized in this bill outside of the settings or organizations specified in this bill.
- Subject to any applicable conflict of interest policies of the bylaws, the NP shall be eligible for membership of an organized medical staff.
- Subject to any applicable conflict of interest policies of the bylaws, an NP member may vote at meetings of the department to which NPs are assigned.

This bill would specify that the APRNB shall issue a certificate to practice outside of the settings and organizations specified in this bill, if, in addition to satisfying the requirements of this article, the NP satisfies all of the following requirements:

- Holds a Master of Science degree in Nursing (MSN) or a Doctorate of Nursing Practice degree (DNP).
- Has practiced as an NP in good standing for at least three years, not inclusive of the transition to practice requirement, as specified. The board may, at its discretion, lower this requirement for an NP holding a DNP based on practice experience gained in the course of doctoral education experience.

This bill would specify that an NP authorized to practice pursuant to this bill must comply with all of the following:

- The NP, consistent with applicable standards of care, shall practice within the scope of their clinical and professional education and training and within the limits of their knowledge and experience.
- The NP shall consult and collaborate with other healing arts providers based on the clinical condition of the patient to whom health care is provided.
- The NP shall establish a plan for referral of complex medical cases and emergencies to a physician and surgeon or other appropriate healing arts provider.

This bill would specify that an NP practicing under this bill outside of the settings or organization, must maintain professional liability insurance appropriate for the practice setting.

This bill would specify that corporations and other artificial legal entities shall have no professional rights, privileges, or powers unless the certificate issued is inactive, surrendered, revoked, or otherwise restricted by the APRNB or the NP is employed pursuant to the exemptions under the ban on the corporate practice of medicine.

The bill would require the board to request DCA's Office of Professional Examination Services, or an equivalent organization, to perform an occupational analysis of nurse practitioners performing certain functions; to take specified measures to identify and assess competencies; and to identify and develop a supplemental examination for licensees if needed based on the assessment, as provided.

According to the author, "as the Legislature and Administration work together to increase coverage, access and affordability to healthcare for all Californian, it is apparent that our current workforce is not equipped to adequately address these goals.

Less than half of the 139,000 licensed physicians in California are actively engaged in providing patient care. Of this number, only 32% are primary care physicians. The distribution of physicians also varies greatly by region with the San Joaquin Valley, Inland Empire and rural areas suffering the greatest shortages. While a number of initiatives, including loan forgiveness and expanded residency programs, have focused on improving this situation, we simply cannot train enough interested primary care physicians and need to engage in additional strategies to meet our workforce needs. One of the top recommendations from the California Health Workforce Commission, representing thought leaders from business, health, employment, labor and government, spent a year looking at how to improve California's ability to meet workforce demands. One of their top recommendations was to allow full practice authority for NPs. This bill aims to accomplish that goal in a measured and reasonable approach."

FISCAL: None

SUPPORT: AARP; Alliance of Catholic Health Care, Inc.; American Nurses Association/California; Anthem Blue Cross; Association of California Healthcare Districts; Association of Community Human Service Agencies; Association of Physician Groups; California Alliance of Child and Family Services; California Association of Clinical Nurse Specialists; California Association for Health Services at Home; California Association for Nurse Practitioners; California Hospital Association; California Naturopathic Doctors Association; California State Council of Service Employees; Casa Pacifica; Congress of California Seniors; Engineers and Scientists of California Local 20, IFPTE AFL-CIO & CLC; Essential Access Health; Hathaway Sycamores; Mental Health Association in California; Providence St. Joseph; Steinberg Institute; Western University of Health Sciences; and Numerous Individuals, including licensed NPs.

OPPOSITION: California Chapter American College of Cardiology; California Chapter of the American College of Emergency Physicians; California Medical Association (unless amended); California Prolife Council and Right to Life Federation (unless amended); California Orthopedic Association; California Society of Plastic Surgeons; Physicians for Patient Protection; and Numerous Individuals, including licensed physicians.

ATTACHMENT: AB 890, Wood. Nurse practitioners: scope of practice.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER:	AB 2239
AUTHOR:	Maienschein
BILL DATE:	March 12, 2020, Amended
SUBJECT:	Health care: physician loan repayment
SPONSOR:	California Psychiatric Association

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require $2,000,000 be annually transferred from the Managed Care Administrative Fines and Penalties Fund to the Medically Underserved Account for Physicians. The bill would define “practice setting” to additionally include a program or facility operated by, or contracted to, a county mental health plan.

BACKGROUND:

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law creates the Managed Care Administrative Fines and Penalties Fund, into which certain fines and penalties paid by health care service plans are deposited. Under existing law, $1,000,000 is annually transferred from the Managed Care Administrative Fines and Penalties Fund to the Medically Underserved Account for Physicians to be used, upon appropriation by the Legislature, to repay the loans of physicians in medically underserved areas through the Steven M. Thompson Physician Corps Loan Repayment Program (STLRP).

Existing law requires participants in the STLRP to have full-time status in an eligible practice setting. Existing law defines “practice setting,” for purposes of the program, to include a community clinic, a clinic owned or operated by a public hospital and health system, or a clinic owned and operated by a hospital that is located in a medically underserved area and at least 50% of whose patients are from a medically underserved population, or a physician owned and operated medical practice setting that provides primary care located in a medically underserved area and has a minimum of 50% of patients who are uninsured, Medi-Cal beneficiaries, or beneficiaries of another publicly funded program.

ANALYSIS:

The bill would require $2,000,000 be annually transferred to the Medically Underserved Account for Physicians within the Health Professions Education Fund and appropriated to the STLRP.

This bill would define “practice setting” to additionally include a program or facility operated by, or contracted to, a county mental health plan.

According to the author, this bill “seeks to address the shortage of qualified mental health professionals by increasing the cap of the Steven M. Thompson Loan Repayment Fund to $2 million for the purpose of loan repayment for psychiatric student loans. There is both a state and national crisis in access to psychiatric services for individuals with a mental illness because of the shortage of psychiatrists available to offer treatment. The National Council for Behavioral Health (2017) notes that demand for psychiatry will exceed available services by 25 percent in the year 2025. The Future Health Workforce Commission (2019) notes that in the next decade the state of California will face a shortfall of psychiatrists with only about two out of three psychiatrists necessary to provide adequate care. The shortage has created critical weaknesses in California’s county operated public mental health care delivery system that serves the most disabled individuals with a mental illness. These individuals have severely disabling disorders like schizophrenia, bi-polar illness, major depression, anxiety and other disorders requiring psychiatric treatment. Without treatment or without timely access to treatment these individuals are at risk of homelessness, arrest and incarceration, repeated hospitalizations, premature death and suicide. Both short- and long-range substantive fixes to increase psychiatric service capacity are needed. Loan repayment programs are one of these and a time-tested way of directing newly trained physicians to underserved areas. County operated mental health delivery systems are not currently authorized settings for awards from the Steven M. Thompson Loan Repayment Program (STLRP), which for nearly 20 years has placed a variety of physicians in underserved communities using loan repayment incentives. Graduates of psychiatric training programs shoulder a heavy burden of debt at the completion of their training which averages $250,000. For further training in subspecialties, debt loads often exceed $300,000.”

This bill will increase the funding for the STLRP by $1,000,000 and expand eligibility for practice settings to include psychiatric care settings, as specified, which will help to incentivize physicians to practice in those areas. This bill would provide much needed funding for the STLRP to assist with loan repayment for physicians who agree to practice in medically underserved areas of the state. This bill would promote access to care and Board staff recommends that the Board take a support position on this bill.

FISCAL: None

SUPPORT: California Psychiatric Association (Sponsor)

OPPOSITION: None on File

POSITION: Recommendation: Support

ATTACHMENT: AB 2239, Maienschein. Health care: physician loan repayment.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER:	AB 2273
AUTHOR:	Bloom
BILL DATE:	February 14, 2020, Introduced
SUBJECT:	Approvals and certificates of registration: special faculty permits
SPONSOR:	Cedars-Sinai

DESCRIPTION OF CURRENT LEGISLATION:

This bill would authorize a special faculty permit (SFP) holder to practice medicine at approved academic medical centers (AMC) that train more than 250 residents. The bill would also expand the definition of "academically eminent" to include persons who hold or have been offered a full-time position at an AMC approved by the Division of Licensing or person who have been offered a full-time position by the chief medical officer of an approved academic medical center, as specified.

BACKGROUND:

Existing law, the Medical Practice Act, prohibits the practice of medicine without a physician's and surgeon's certificate issued by the Medical Board of California (Board). Under existing law, any person who meets certain eligibility requirements, including, but not limited to, the requirement that the person is academically eminent, as defined, may apply for a SFP that authorizes the holder to practice medicine, without a physician's and surgeon's certificate, within the medical school itself and certain affiliated institutions.

ANALYSIS:

This bill would authorize an SFP holder to practice medicine in an approved AMC that trains more than 250 residents.

This bill would expand the definition of "academically eminent" to include a person who is clearly outstanding in a specific field of medicine or surgery and has been offered a full-time academic appointment at the level of full professor or associate professor by the chief medical officer of an approved AMC, as defined.

According to the sponsor, current law allows only approved medical schools to allow themselves of Business and Professions Code Sections 2168, 2113 and 2111, limiting the flexibility of independent academic medical centers to appoint foreign trained physicians without seeking the support of a medical school. Doing so forces the academic medical center to engage in the medical school's administrative processes and delays the ability for the physician to become an active clinician, treating patients in

California. This legislation will allow Cedars-Sinai and a few other prominent institutions to recruit those few but important luminary physicians and physician/scientists, as well as junior physicians with very specialized expertise (B&P Code Sections 2113 and 2111), from other countries to California.

Currently, the Board does not approve AMCs. If the Board will be required to approve AMCs, then the Board would need to adopt regulations to define the parameters in what would be required for approval. Further, the Board does not have expertise on approving hospitals and would likely have to contract with an outside subject matter expert to evaluate the AMCs. Currently, SFPs are intended for medical education institutions and affiliates, and would be reviewed by the committee which is comprised of one representative from each of the medical schools in California and two Medical Board members, as specified. This bill does not expand membership of the committee to representatives from the AMCs. Further, current law makes it clear that the medical school that appointed the SFP holder assumes direct responsibility for that individual. There is no similar provision in this proposed legislation requiring the AMC to assume direct responsibility for the SFP holder. The Board should consider these issues in its discussion on this bill.

FISCAL:

SB 2273 may result in significant cost to the Board if the Board will be required to approve AMCs and hold SFP meeting for a newly, created committee. The Board would likely have to contract with an outside subject matter expert to evaluate the AMCs.

SUPPORT: Cedars-Sinai (Sponsor)

OPPOSITION: None on File

ATTACHMENT: AB 2273, Bloom. Approvals and certificates of registration: special faculty permits.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER:	AB 2478
AUTHOR:	Carrillo
BILL DATE:	February 19, 2020, Introduced
SUBJECT:	International medical graduates: study
SPONSOR:	AltaMed

DESCRIPTION OF CURRENT LEGISLATION:

This bill directs the Medical Board of California (Board) to conduct a study on increasing the existing pool of international medical graduates (IMGs).

BACKGROUND:

Existing law, the Medical Practice Act, establishes the Board for the licensure and regulation of physicians and surgeons. Existing law establishes the University of California at Los Angeles David Geffen School of Medicine's International Medical Graduate Program to allow selected international medical graduates in a preresidency training program at the University of California, Los Angeles David Geffen School of Medicine, Department of Family Medicine, to receive hands-on clinical instruction, as prescribed.

ANALYSIS:

This bill would state the Legislature finds and declares:

- Bilingual international medical graduates can help meet the needs of medically underserved regions with limited English proficient populations.

- There is an increasing number of undergraduate students born in the United States who attend medical school in foreign Spanish-speaking countries, and are considered international medical graduates.

- Spanish-speaking physicians, including Spanish-speaking international medical graduates, are highly underrepresented in California's physician workforce.

- California needs Spanish-speaking physicians to meet the needs of Spanish-speaking limited English proficient patients more than any other linguistically underrepresented language group.

- The current supply is limited and insufficient to address the expected demand from the limited English proficient Spanish-speaking population.

This bill would state the intent of the Legislature is to expand the existing pool of IMGs in the state.

This bill would require the Board to conduct a study by January 1, 2022, on achieving the following goals:

- Recruiting bilingual physicians trained in Spanish-speaking countries, and facilitating their practice in medically underserved areas with high Latino populations, including, but not limited to, Los Angeles, Orange County, the Central Valley, and the Inland Empire.

- Supporting international medical graduates training programs that enhance primary care residency match competitiveness.

- Identifying and supporting programs that help prepare international medical graduates to match in a competitive residency program in a primary care specialty, including family medicine, internal medicine, and pediatrics.

- Expanding the terms of service to priority areas to five-year terms for physicians and surgeons to retain international medical graduates in underserved areas for extended times.

- Adding a service contract requirement for those who enter the United States via J-1 and H1B visas, as these physicians do not currently have service requirements and are a potential source of bilingual primary care physicians.

The bill would require the Board, on or before January 1, 2022, to prepare and submit to the Legislature a report with recommendations to achieve the specified goals.

According to the sponsor, “California is experiencing an increasing shortage of primary care physicians, which is only expected to increase with an aging population. Unfortunately, those areas lacking the most access to medical services have high Latino, Black and Native American populations. As the Latino population continues to grow, the number of Latino physicians has not been able to catch up due to existing barriers such as financial costs, academic barriers, under representation and citizenship issues. California needs Spanish-speaking physicians to meet the needs of limited English proficient patients. There is an increasing number of undergraduate students born in the United States who attend medical school in Spanish-speaking countries, and who are considered IMGs. Spanish-speaking physicians are highly underrepresented in California’s physician workforce. Expanding IMG programs will help increase the supply of Latino physicians needed to address the growing demand in underserved areas.”

This bill seeks to help medically underserved regions with limited English proficient populations, by increasing bilingual physicians and supporting IMG training programs.

This bill will require the Board to conduct a study and submit the report to the Legislature. The Board does not have expertise in the area of the requested study and therefore would need to contract with an outside entity to perform the study. This will have a significant cost to the Board ranging from approximately $200,000 to $500,000. Board staff recommends that the Board take an oppose position on this bill.

FISCAL:

AB 2478 will result in a significant cost to the Board. The Board is estimating that the cost of the study would range from $ 200,000 - $500,000 The Board will need to contract with an outside entity to perform the study. The Board's current fund condition could not absorb these significant costs and funding for this study is not accounted for in the Governor's proposed FY 2020-21 budget.

SUPPORT: None on File

OPPOSITION: None on File

POSITION: Recommendation: Oppose

ATTACHMENT: AB 2478, Carrillo. International medical graduates: study.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER:	SB 1237
AUTHOR:	Dodd
BILL DATE:	February 20, 2020, Introduced
SUBJECT:	Nurse-midwives: scope of practice
SPONSOR:	California Nurse Midwives Association and Black Women for Wellness Action Project

DESCRIPTION OF CURRENT LEGISLATION:

This bill would remove the "physician permission to practice law" for certified nurse-midwives (CNM). This bill would define what collaborative care is between physicians and CNMs and create the foundation for consultation, co-management and seamless transfer of care when needed.

BACKGROUND:

Existing law, the Nursing Practice Act, establishes the Board of Registered Nursing within the Department of Consumer Affairs for the licensure and regulation of the practice of nursing. Existing law requires the board to issue a certificate to practice nurse-midwifery to a person who, among other qualifications, meets educational standards established by the board or the equivalent of those educational standards. Existing law authorizes a CNM, under the supervision of a licensed physician and surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother, and immediate care for the newborn. Existing law defines the practice of nurse-midwifery as the furthering or undertaking by a certified person, under the supervision of licensed physician and surgeon who has current practice or training in obstetrics, to assist a woman in childbirth so long as progress meets criteria accepted as normal. Existing law requires all complications to be referred to a physician immediately. Existing law excludes the assisting of childbirth by any artificial, forcible, or mechanical means, and the performance of any version from the definition of the practice of nurse-midwifery.

Existing law authorizes the board to appoint a committee of qualified physicians and nurses, including, but not limited to, obstetricians and CNMs, to develop the necessary standards relating to educational requirements, ratios of CNMs to supervising physicians, and associated matters. Existing law, additionally, authorizes the committee to include family physicians.

Existing law authorizes a CNM to furnish drugs or devices, including controlled substances, in specified circumstances, including if drugs or devices are furnished or ordered incidentally to the provision of care in specified settings, including certain licensed health care facilities, birth centers, and maternity hospitals provided that the

furnishing or ordering of drugs or devices occur under physician and surgeon supervision.

Existing law authorizes a CNM to perform and repair episiotomies and repair lacerations of the perineum in specified health care facilities only if specified conditions are met, including that the protocols and procedures ensure that all complications are referred to a physician and surgeon immediately, and that immediate care of patients who are in need of care beyond the scope of practice of the CNM, or emergency care for times when the supervising physician and surgeon is not on the premises.

ANALYSIS:

This bill would establish the Nurse-Midwifery Advisory Committee to develop the necessary standards relating to educational requirements and all matters related to the practice of nurse-midwifery. The committee may include, but not be limited to, qualified nurses and qualified physicians and surgeons, including, but not limited to, family physicians. A majority of the members of the committee shall be CNMs.

The bill would authorize a CNM to attend cases of normal pregnancy and childbirth and to provide prenatal, intrapartum, and postpartum care, including gynecologic and family-planning services, interconception care, and immediate care for the newborn, consistent with the Core Competencies for Basic Midwifery Practice adopted by the American College of Nurse-Midwives, or its successor national professional organization, as approved by the board. This bill would specify that a CNM should emphasize informed consent, preventive care, and early detection and referral of complications to physicians and surgeons.

This bill would specify that the practice of nurse-midwifery includes “consultation,” “comanagement,” or “referral” as indicated by the health status of the patient and the resources and medical personnel available in the setting of care, subject to the following:

- The certificate to practice nurse-midwifery authorizes the holder to work collaboratively with a physician and surgeon to co-manage care for a patient with more complex health needs. The scope of “co-management” may encompass the physical care of the patient, including birth, by the CNM, according to a mutually agreed upon plan of care with the physician and surgeon. If the physician and surgeon must assume a lead role in the care of the patient due to an increased risk status, the CNM may continue to participate in physical care, counseling, guidance, teaching, and support, according to a mutually agreed upon plan.

- After a CNM refers a patient to a physician and surgeon, the CNM may continue care of the patient during a reasonable interval between the referral and the initial appointment with the physician and surgeon.

- A patient shall be transferred from the primary management responsibility of the CNM to that of a physician and surgeon for the management of a problem or aspect of the patient's care that is outside the scope of the CNM's education, training, and experience. A patient that has been transferred from the primary management responsibility of a CNM may return to the care of the CNM after resolution of any problem that required the transfer or that would require transfer from the primary management responsibility of a CNM.

This bill would specify that a CNM is authorized to attend pregnancy and childbirth in an out-of-hospital setting if all of the following conditions apply:

- Neither of the following are present:
    - A pre-existing maternal disease or condition creating risks higher than that of a low-risk pregnancy or birth, based on current evidence and accepted practice.
    - Disease arising from or during the pregnancy creating risks higher than that of a low-risk pregnancy or birth, based on current evidence and accepted practice.
- There is a singleton fetus.
- There is cephalic presentation at the onset of labor.
- The gestational age of the fetus is at least 37 completed weeks of pregnancy and less than 42 completed weeks of pregnancy at the onset of labor.
- Labor is spontaneous or induced in an outpatient setting.

This bill would specify that a CNM is not authorized to assist childbirth by vacuum or forceps extraction, or to perform any external cephalic version.

This bill would require a CNM to maintain clinical practice guidelines that delineate the parameters for "consultation," "co-management," "referral," and "transfer" of a patient's care.

This bill would require a CNM to document all consultations, referrals, and transfers in the patient record.

This bill would require a CNM to refer all emergencies to a physician and surgeon immediately. A CNM may provide emergency care until the assistance of a physician and surgeon is obtained.

This bill would specify that a CNM may furnish or order drugs or devices in accordance with standardized procedures or protocols, as specified. This bill would specify that a

CNM may directly procure supplies and devices, obtain and administer diagnostic tests, order laboratory and diagnostic testing, and receive reports that are necessary to their practice as a CNM within their scope of practice.

This bill would specify that a CNM may perform and repair episiotomies, and to repair first-degree and second-degree lacerations of the perineum if the CNM ensures the following:

- that all complications are referred to a physician and surgeon immediately; and

- that immediate care of patients who are in need of care beyond the scope of practice of the CNM, or emergency care for times when a physician and surgeon is not on the premises.

According to the author of this bill, "[t]here is a direct link between race and access to maternity care nationwide. This is a complex problem requiring multiple innovative strategies in order to turn the tide. Improving access to nurse-midwifery care has been named by leading organizations, such as the March of Dimes and the World Health Organization, as one of these innovative strategies in addressing these racial disparities. Removing unnecessary supervision requirements for Certified Nurse Midwives in California will allow the nurse-midwifery profession to expand and grow as well as integrate more fully into a team-based model of care with physicians, improve outcomes, and expand access in the most marginalized communities. Nurse-Midwifery is a well-established profession in California with approximately 1000 nurse-midwives already attending 50,000 births in California annually. Over 95% of births attended by nurse-midwives occur in the hospital. Other sites of care include the home, birth centers, and outpatient care in the clinic setting. However, California is 1 of only 4 states in the nation that still requires physician supervision in order for nurse-midwives to practice."

The bill would delete the condition that a CNM practice under the supervision of a physician and surgeon and would instead authorize a CNM to attend cases of normal pregnancy and childbirth and to provide prenatal, intrapartum, and postpartum care, including gynecologic and family-planning services, interconception care, and immediate care of the newborn, consistent with standards adopted by a specified professional organization, or its successor, as approved by the board.

Among other restrictions, this bill prohibits CNMs from attending pregnancy and birth in out-of-hospital settings if there is a pre-existing maternal disease or condition creating risks higher than that of a low-risk pregnancy or birth, based on current evidence and accepted practice. However, this bill does not specifically address the issue of allowing CNMs to perform out-of-hospital vaginal births after cesarean section (VBAC) without a physician consult and approval, and may create similar tensions and confusion that exist in licensed midwifery practice. The Board should consider these issues in its discussion on this bill.

FISCAL: None

SUPPORT: California Nurse Midwives Association (Co-sponsor)
Black Women for Wellness Action Project (Co-sponsor)
Academy of Lactation Policy and Practice
American Association of Birth Centers- CA
American Nurses Association/CA
CA Women's Law Center
Citizens for Choice Feminist
Majority Foundation Healthy
Children Project, Inc.
MomsRising

OPPOSITION: None on File

ATTACHMENT: SB 1237, Dodd. Nurse-midwives: scope of practice.