MEDICAL BOARD OF CALIFORNIA
Licensing Program

MIDWIFERY ADVISORY COUNCIL

August 13, 2015

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

MEETING 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 1:05 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.
Barbara Yaroslavsky
James Byrne, M.D.

Members Absent:
Monique Webster

Staff Present:
Diane Dobbs, Department of Consumer Affairs, Legal Counsel
Amanda Jantz, Office Technician
Kimberly Kirchmeyer, Executive Director
Natalie Lowe, Licensing Manager
Regina Rao, Associate Analyst
AnnaMarie Sewell, Licensing Analyst
Jennifer Simoes, Chief of Licensing
Kerrie Webb, Legal Counsel
Curtis Worden, Chief of Licensing

Members of the Audience:
Bruce Ackerman, Midwives Alliance of North America
Jen Brown, L.M.
Rosanna Davis, L.M., California Association of Midwives
Faith Gibson, L.M., California College of Midwives
Diane Holzer, L.M.

Kaleem Joy, L.M.
Laura Maxson, L.M.
Lesley Nelson, L.M.
Martine Wilson
Shannon Smith-Crowley, American College of Obstetricians and Gynecologists
Linda Walsh, California Nurse-Midwives Association

Agenda Item 2 Public Comment on Items not on the Agenda

No comments were provided.

Agenda Item 3 Approval of the March 26, 2015 Midwifery Advisory Council Meeting Minutes

Ms. Lowe stated that MAC members had provided edits to Board staff prior to the meeting and the following changes would be updated in the minutes: on page four of the minutes, the first paragraph, the title "California Family Access to Midwives" would be corrected to "California Families for Access to Midwives"; and on page ten of the minutes, the last paragraph, the sentence beginning with "Ms. Sparrevohn added" would be struck as it was redundant to the paragraph that followed on page 11 of the minutes.

Ms. Sparrevohn motioned to approve the March 26, 2015 minutes with edits; s/Ms. Yaroslavsky. Motion carried.

Agenda Item 4 Report from the Midwifery Advisory Council Chairperson

Ms. Sparrevohn briefly discussed the challenges facing midwifery practice in California and across the country, indicating that the top challenge is the ability to train more midwives.

Ms. Sparrevohn indicated that she had attended the US Midwifery Education, Regulation, and Association (US MERA) 2015 annual meeting in April, and that the American Congress of Obstetricians and Gynecologists (ACOG) president had stated that they are expecting a projected 8,000 obstetric shortfalls in the future and that more midwives were needed. Ms. Sparrevohn continued, that as a community of midwives, students, preceptors, and practicing midwives, midwives needed to start thinking of how they were going to economically, swiftly, and with excellence, train more midwives in the State of California, and that community college programs may be a possible solution.

Ms. Sparrevohn acknowledged that there has been a road block in negotiations between midwives and physicians regarding the vaginal birth after cesarean (VBAC) issue, and encouraged everyone to meet again to create regulations that not only provide for women's safety, but also provide for their autonomy of choice.

Ms. Sparrevohn stated that there is a need to finish the current legislation session and hopefully the two laws that affect midwives will be passed in a way that works for everybody. Ms. Sparrevohn encouraged those that are interested to become more engaged in midwifery issues on a national basis, seek out national organizations, and to volunteer.

Agenda Item 5 Licensed Midwife Annual Report Taskforce

Ms. Sparrevohn referred to the report provided in the meeting materials, indicating that the document was an updated version of the report that had been discussed at the March MAC meeting.

Ms. Sparrevohn recommended adding a field to delineate between the number of transfers that were primips versus multips, as the transfer rate for multips was less frequent than primips. Ms. Sparrevohn clarified that a primip is woman who has never delivered a baby, and a multip is someone that has had a baby before.

Ms. Sparrevohn moved on to the subject of vaginal birth after cesarean section, recommending that VBAC information replace Section P of the current LMAR. Ms. Sparrevohn stated that the current tool captures how many successful VBACs were performed, but does not capture critical information such as whether the VBAC was planned, if the labor started at home, and if a transfer was required. Ms. Sparrevohn added that by creating a section specific to VBAC information and removing from all other areas of the report, it might provide an more accurate portrayal of the VBACs being performed by midwives.

Ms. Sparrevohn stated that in the current version of the LMAR, data pertaining to death may be skewed as it can be reported in more than one section on the current report. She recommended having one section on the report to capture all deaths, including specific information on each death, such as: what contributed to the death, how many weeks was the gestation, and other factors surrounding the death.

Ms. Lowe stated that following the March MAC meeting, Board staff and legal counsel reviewed the changes being requested as well as the laws relating to data collection for midwives. All of the requested changes that were documented fell into one of three categories: minor fixes to the current system, requests that would require legislative changes, or requests that would require major programming to the system.

Ms. Lowe stated that the minor fix was to remove the option of selecting “no data to report” as the system currently required the user to go back and remove any zeros that had been entered, and to simply require the user to enter data into each field.

Ms. Lowe stated that removing the requirements from the LMAR to capture data by county would require a legislative change. Ms. Lowe stated that changes made to the section pertaining to VBACs would be on hold pending the completion of the midwifery regulations that were currently pending.

Ms. Lowe stated that following review of the requested changes, staff began looking into how the changes could be implemented. Contact was made with the Board’s IT Department and with Office of Statewide Health Planning and Development (OSHPD) to begin discussions. During discussions with OSHPD one of the concerns raised was that currently the Board held a Memorandum of Understanding (MOU) with OSHPD that states OSHPD will only provide 40 hours of service to the LMAR system per year, making it very unlikely that the changes could be implemented by OSHPD. Based on this information the Board agreed that once all requirements to the updated system could be obtained, the Board’s IT Department would begin programming a new system which could then be delivered to OSHPD to maintain.

Ms. Lowe stated that Board staff will be holding an Interested Parties meeting on October 13, 2015, to further discuss the requested changes to the LMAR. Once feedback has been obtained, staff, along with Ms. Sparrevohn, will create a design plan for the program, and will attempt to create a physical copy of the report that can then be presented at the MAC meeting in December, and if approved, move forward to the Full Board in February. Once approved by the Board, staff will then proceed with creating the system.

Ms. Lowe stated that between the IT Department, utilizing Ms. Sparrevohn as a subject matter expert, and obtaining feedback from the Interested Parties meeting, she was confident that the needs of the midwifery community, the Board, and OSHPD could be met.

Ms. Yaroslavsky questioned that if someone were to state that a pregnancy had gone 37 weeks, three days, and two hours, how would one know that information. Ms. Yaroslavsky stated that her concern was when it states gestation greater than or less than, if it was a defined term, and if so, would the MAC be holding midwives to a standard that was actually guessing.

Ms. Sparrevohn stated that term pregnancy is defined as a pregnancy that is 37 0/7th weeks up to 42 weeks and zero days. Ms. Sparrevohn indicated that midwives are not allowed to attend births outside of that range, but it was not an exact science, and users would need to report to the best of their ability.

Dr. Byrne indicated that he believes the range for the pregnancy term was taken from the Centers for Disease Control and Prevention (CDC) definitions.

Dr. Byrne stated that he had seen reports from OSHPD where they had used the maternal zip code as the indicator and wondered if maternal zip code could be collected in the LMAR, in order to be able to compare the vital records reporting that OSHPD is doing in other areas. Dr. Byrne stated that collecting maternal zip code would make it clearer if people were traveling out of their area to receive care, and whether it was home birth care versus pediatric cardiac surgery. Dr. Byrne indicated that obtaining the maternal zip code would be beneficial in identifying the county when looking at preterm birth rates throughout California in order to help determine if there were environmental, or other factors related.

Ms. Sparrevohn questioned the legal ability to collect the maternal zip code for each incident in the section for losses.

Ms. Webb responded that it was not currently provided for in statute and would require a legislative change in order to request the information.

Ms. Davis stated that the reason for requesting that the county be removed from the LMAR was to protect the privacy of the midwife and the mother, and that by adding the maternal zip code it could be even more identifying. She also opined that by adding zip codes it could potentially be cumbersome work when completing the LMAR.

Ms. Sparrevohn agreed that Dr. Byrne's recommendation to include the maternal zip code might be helpful, but could also be more identifying to the midwife and mother.

Ms. Yaroslavsky stated that the maternal zip code could be valuable and provide critical information as far as need for services, availability of services, and environmental concerns of services; but felt that the item should be discussed further at the Interested Parties meeting.

Ms. Sparrevohn stated that when Ms. Gibson and herself were involved with the writing of the legislation, they felt that more midwives would comply 100% if there was no way to identify the midwife. Ms. Sparrevohn stated that some of what Ms. Yaroslavsky had mentioned may be available from the hospital reporting forms.

Dr. Byrne stated that he was cautious because even though there was good intention to protect the midwife, by not collecting this, helpful information may be shaded. Dr. Byrne provide an example that by collecting the maternal zip code one might show that in a particular zip code the most successful birth rates were with licensed midwives.

Dr. Byrne suggested that Board staff check if the reporting would be protected under Business and Professions Code section (B&P) 1157 which provides the freedom from discovery for peer review processes which are intended to improve safety and care in medical settings. Dr. Byrne stated that it would seem midwives would get the value of providing the information if they were protected under B&P 1157.

Ms. Lowe stated that data would still be collected by OSHPD, who would continue to aggregate the data and provide a summary report to the Board at the end of the reporting period. No patient information, whether maternal or fetal, would be provided to OSHPD. Ms. Lowe clarified that only the reporting of fetal demise must be reported by county pursuant to statute, but that other data elements did not. Ms. Lowe added that until the statute changes, the LMAR report would continue to collect the information by county.

Ms. Ehrlich suggested obtaining a county by county listing for total numbers of births, as understanding the demographics of where a birth has occurred could be valuable.

Ms. Gibson stated that the California College of Midwives was in favor of continuing to report by county.

Mr. Ackerman stated that the Midwife Alliance of North America (MANA) report collects maternal zip code and suggested that it could be an additional element to the revised LMAR.

Mr. Ackerman referred to Dr. Byrne and other's comments regarding the concern between the requirements for privacy and the needs of the society to have good data, in particular, it was mentioned that MANA was looking for diseases or anything that might be correlated with geography.

Mr. Ackerman clarified that the process of analyzing data that has been submitted is often handled through the research process and by having a data base, which is fundamentally what the MANA stats system is. Mr. Ackerman suggested utilizing MANA for collecting the required data.

Agenda Item 6 Update on Licensed Midwife Legislation

Ms. Simoes provided an update on Assembly Bill (AB) 1306 (Burke), the bill regarding the certified nurse midwives, which had been significantly amended on July 1, 2015. The Board previously had an opposed unless amended position; however, the amendment on July 1, 2015 addressed many of the Board's concerns. The bill was held in the Senate Business and Professions Committee and therefore was not taken to the Board because it was now a two year bill.

The Board asked that the bill be structured similar to how AB 1308 was for licensed midwives, as well as that it include physician members on the Nurse-Midwifery Advisory Council, both of which have been done. The bill puts parameters on the settings where a Certified Nurse Midwife (CNM) can practice, and what clients a CNM can accept in a home setting. For CNMs practicing in a home setting, the bill would require CNMs to consult with a physician trained in obstetrics and gynecology for clients that have had a preexisting maternal disease or condition likely to complicate the pregnancy, a disease arising from the pregnancy likely to cause significate maternal and or fetal compromise, or a prior cesarean delivery. A CNM may assist the woman in pregnancy and child birth only if the physician that performed the consultation determines that the risk factors presented by her disease or condition are not likely to significantly affect the course of pregnancy in child birth. The legislature will reconvene in January 2016 for further review of the bill.

Ms. Simoes provided an update on Senate Bill (SB) 407 (Morrell), stating that the Board does not have a position on the bill. The bill, which is currently in the Assembly Appropriations Committee, will add licensed midwives to the list of providers that a health care provider may employ or contract with to provide comprehensive perinatal services for the Comprehensive Perinatal Services Program (CPSP). The bill originally added licensed midwives as providers; however, the latest amendments specified that only on the effective date of the regulations being adopted by the Board pursuant to AB 1308 would licensed midwives be eligible to serve as providers.

Ms. Sparrevohn commented that unless a licensed midwives is a provider of CPSP at a birth center, the licensed midwife cannot be a licensed birth center in California.

Ms. Simoes provided an update on SB 408 (Morrell), a Board sponsored bill that is currently on the Assembly consent calendar. Once it passes out of the Assembly it will go to the Governor for signature. The bill defines midwife assistants in statute. The bill will assure midwife assistants meet minimum training requirements and will set forth duties that a midwife assistant can perform that are technical supportive services only. Midwife assistants would only be allowed to perform these technical supportive services under the supervision of a licensed midwife or certified nurse midwife.

Ms. Yaroslavsky questioned if SB 407 was the first step toward what will be looked at as a collaborative care model or if it was specifically related to spending money for Medi-Caid for people that do not have insurance.

Ms. Sparrevohn clarified that SB 407 is a bill to add licensed midwives to a list of providers and practitioners that can provide comprehensive perinatal services to Medi-Cal clients in order to be reimbursed.

Agenda Item 7 Update on Continuing Regulatory Efforts Required by Assembly Bill 1308

Ms. Webb provided an update on AB 1308 and indicated that two previous Interested Parties meetings were held in October and December 2014, to discuss the language for the regulations needed to define preexisting maternal disease or condition likely to affect the pregnancy and significant disease arising from the pregnancy. Ms. Webb stated that the Board was hopeful that an agreement could be reached on whether midwives could assist their clients with any category of vaginal birth after cesarean (VBAC) without a prior physician consult and determination by the physician that the risk factors presented by the client's disease or condition were not likely to significantly affect the course of the pregnancy or child birth.

Ms. Webb stated that the ACOG's position continued to be that no VBACs assisted by midwives should be performed without a prior physician consult and determination. Midwives and consumer groups have taken the position that midwives should be able to assist with certain categories of VBACs without a prior physician consult and determination.

Ms. Webb stated that the pending regulations may now be impacting other statutes, as seen in SB 407. ACOG was able to successfully lobby to delay the inclusion of licensed midwives as comprehensive perinatal providers until the B&P section 2507 regulations become effective. Ms. Webb added that a resolution was still in process.

Ms. Sparrevohn questioned if the Board will be holding a third Interested Parties meeting on the item.

Ms. Webb indicated that the Board is open to an additional Interested Parties meeting if there is a change in discussion.

Ms. Sparrevohn questioned how scientific data surrounding VBAC and VBAC issues, outcomes, risks, and benefits, come into play in the Board's decision to include, or not include, categories of VBACs in the regulation, as opposed to the interested parties making statements regarding the subject without data to support their statements. Ms. Sparrevohn questioned if there was a way for the interested parties to put forth evidence on one side of the issue or another that could then be used to create the regulation.

Ms. Webb answered positively and indicated that there are mixed reviews and recommendations that have been made. Ms. Webb stated that she cannot speak to how the Board will vote; however, the process could be prolonged and could prompt litigation if the stakeholders have not reached a consensus on the language going into the regulation.

Ms. Gibson commented that the issue for midwives, in her opinion, was how the physician consultation would increase safety at the time of the birth for a pregnant woman who had a previous cesarean. Ms. Gibson indicated that the only thing she could see, was the usefulness of an ultrasound, because there would be a higher likelihood of the placenta having some form of previa and/or some kind of improper implantation, both of which could be seen on an ultrasound.

Dr. Byrne stated that he felt it was important for women to have access to VBACs and available information in order to make an informed decision. Part of the informed decision process in his center, is to make sure that patients are aware of their opportunities for VBAC, relative to the published data

regarding the likelihood of success of their trial of labor for VBAC, the strong benefits for a VBAC, and also the potential risks. Dr. Byrne concluded that the benefit of the consultation will be to ensure informed decision making and that the patients are aware of what they have available to them as resources.

Ms. Ehrlich stated that if a woman is required to go to an obstetrician and gynecologist (OB/GYN) she would have an ultrasound. Ms. Ehrlich questioned why midwives could not require the evidence of an ultrasound and not require the patient see an OB/GYN in order to do that. Ms. Ehrlich also responded to Dr. Byrne's statement about the benefit of patients having thorough and informed consent, and responded that midwives in the State of California have been ensuring patients have available information to make an informed consent since the regulation was passed in 2005. Midwives have been required to provide thorough and informed consent to women, in order to accept them for midwifery care.

Dr. Byrne referred to midwifery-led VBAC and stated that the chance of a uterine rupture was around one-half percent, and the chance of the baby having a neurologic injury or death was only about one percent of those. Based on that, the risk was about one out of a thousand for the baby to die or have brain injury. Dr. Byrne stated that those were great odds in the woman's favor, and does not personally see a concern about a physician consult.

Ms. Ehrlich stated that midwives are health care providers, and they have incredible value for informed consent, possibly more than mainstream medical care. Ms. Ehrlich stated that she understood that Dr. Byrne wants full informed consent, as do midwives, and that it was an insult to the midwives in California to think that a doctor would be the only health care provider capable of providing that kind of informed consent.

Dr. Byrne responded that no one was taking it as an insult that a woman with hypertension or severe diabetes should obtain a consult and that he was not trying to interject any sense of superiority, only that he was speaking about what information women should have.

Ms. Ehrlich stated that she disagrees that an OB/GYN must provide that information in order for it to be thorough enough to not be suspect.

Ms. Sparrevohn stated that she felt the biggest concern among midwives and the public over the VBAC issue and requiring a physician consult, was that there may not be a physician with similar opinions to Dr. Byrne in their community. Ms. Sparrevohn continued that there are many communities in the state where a woman will not even be able to get a consult, and if she does she will have to not say she is planning a home birth, which does not give her good informed consent.

Ms. Sparrevohn stated that there is a concern that a physician who knows that a woman is planning a home birth may not be willing to go on record saying that the risk factors presented by the woman's disease or condition were not likely to significantly affect the course of pregnancy and childbirth, and midwives are worried that the physician's malpractice insurance may instruct the physician to not do it.

Ms. Sparrevohn continued that if the discussion was truly about whether a woman has informed consent or not, a regulation should be written that details what informed consent should be. Previous regulation

required midwives to inform the woman of the level of training that the midwife had in performing VBACs, and to provide the woman with a copy of ACOG's latest statement on VBACs.

Dr. Byrne questioned why VBACs were being singled out when there were also other maternal health issues designated by regulation.

Ms. Ehrlich responded that it was because 30 percent of women in the state and in the country are having cesareans, and many of them would like to have a vaginal birth after, but are unable to do so. Throughout the state there are many hospitals that simply will not allow it. There are many OB/GYNs throughout the state who will say they are open to the VBAC approach and then will change their plan later in the pregnancy term and schedule a cesarean.

Dr. Byrne stated that he understood the concerns and because the issue was about access to care, he was concerned that if there were too many restrictions it would further hinder that access. Dr. Byrne mentioned that he was under the impression that 90 to 95 percent of California's population was within 40 miles of a facility that could do a VBAC, and used the Los Angeles area as an example.

Ms. Ehrlich commented that if one was speaking of Los Angeles, then the population should not be looked at, rather the community should be, and what percentage of communities in California that do not have a hospital within 40 miles.

Dr. Byrne indicated that he was looking at the population.

Ms. Ehrlich stated that she cared about the women in rural California who may want a VBAC and not have access. Ms. Ehrlich added that she cared about the fact that when women are denied the access that they want, there are highly increased chances that they will have an unattended home birth, which is far more dangerous for them.

Ms. Sparrevohn addressed Dr. Byrne's question regarding why midwives had singled out VBACs. Ms. Sparrevohn stated that midwives were experts on VBACs but were not experts on other maternal health issues such as hypertension, thyroid disease, or cardiac problems.

Dr. Byrne stated that prior cesarean section is a recognized maternal status by the World Health Organization, and does place increased risk of complication during labor. He continued that the issue is very straight-forward and non-emotional from his perspective and that it is something that women should be encouraged to have, if the regulations are such that risk factors that can impact the maternal/child outcomes require a consultation.

Ms. Webb clarified that the statute states "likely" to impact, which was a significant word in the statute.

Dr. Byrne stated that 50/50 is not "likely" to impact in a medical sense. When things start getting into risk of 1 out of a 1,000 or 1 out of 10,000, there is intervention. Dr. Byrne stated that out of all of the different conditions, VBAC was one condition that should not be separated from hypertension and the other conditions. Dr. Byrne stated that there should be a clear discussion and thought the information would help empower women.

Ms. Sparrevohn agreed that sending her client to Dr. Byrne may empower her; however, not all physicians would be the same.

Ms. Sparrevohn felt that women should be provided with accurate data regarding VBACs in order to make an informed decision and that those data elements would first need to be outlined in regulation.

Ms. Gibson stated that midwives are still referring to the past regulations pertaining to patient consent and VBAC issues. Ms. Gibson added that what makes VBAC different is the legal entanglement for the physicians who are providing consultations and that she would be happy to refer clients for a consultation if the physician involved knew that they could not be sued relative to their advice or lack thereof.

Ms. Webb clarified that Title 16 of the California Code of Regulation, section 1379.19, Standards of Care for Midwives, was still in print because there has not been a formal repeal of it, but that AB 1308 had removed the authority for the Standard of Care in regulation which is why the Board went through the process of creating the guidelines that were modeled after the Standard of Care.

Ms. Sparrevohn stated that it effectively repealed the requirements for VBAC.

Ms. Gibson stated that it does not prevent midwives from using informed consent, but it was not legally required.

Ms. Sparrevohn stated that it was probably a good idea to keep using it while regulations were not in place.

Ms. Holzer questioned if it was prohibited for a midwife to attend a VBAC at home.

Ms. Webb stated that it was not prohibited, and that VBACs were being done, but that midwives needed to follow the community standard of care in deciding whether to take on and retain particular clients.

Ms. Ehrlich stated that it was her understanding that midwives have obtained copies of letters from the malpractice insurance industry stating that no OB/GYN may provide any aid, assistance, consult, or backup for any woman who is planning a home birth.

Dr. Byrne stated that he knows of physicians who support midwives in their community who are NORCAL providers.

Ms. Ehrlich requested Dr. Byrne contact NORCAL to ask for their opinion and to request they write a letter about what kind of assistance physicians may provide for women planning a home birth.

Dr. Byrne indicated he would contact NORCAL regarding the issue.

Agenda Item 8 Update on the Challenge Mechanism

Ms. Lowe stated that staff had presented the findings on Maternidad La Luz's challenge program, which had been updated to meet the requirements of B&P 2513(a), to the Board at the July 31, 2015 Quarterly

Board meeting, at which time the Board approved the continuation of the program. Ms. Lowe added that National Midwifery Institute had provided information to staff that they were not currently prepared to submit documentation for their new program, but were hopeful to do so in the future. Currently, Maternidad La Luz is the only approved challenge program.

Agenda Item 9 Program Update

A. BreEZe

Ms. Lowe provided an update on BreEZe, stating that staff are preparing for the next release of the system which should take place during the beginning of next year. Prior to that release, staff will be testing all transactions to ensure that there are no regression issues. Ms. Lowe stated that following the release, staff are hopeful that additional resources will be available to focus on the Board's concerns, including the pending change requests.

Ms. Yaroslavsky asked if the applications that are currently being processed for midwifery are being done in BreEZe.

Ms. Lowe confirmed that the applications are being completed in–house utilizing BreEZe and provided a brief description of how a midwifery application is processed.

Ms. Yaroslavsky questioned if licensees are able to look up their application status through the BreEZe system.

Ms. Lowe stated that for midwifery applicants, they cannot submit their application online currently; however, if an application had been submitted and entered into the BreEZe system by staff, an applicant could on-board their application and review the status. Ms. Lowe stated that currently, when viewing the available information, it would only indicate the status, whether it was opened or approved. Ms. Lowe added that in the future, any deficiencies for an application would be displayed, and anticipates the functionality being available once the midwifery application is added to the online system.

Ms. Yaroslavsky requested that a notification be sent to licensed midwives informing them of the service once it is available.

Ms. Lowe confirmed that midwives will be notified of the information once the functionality is available online.

Ms. Yaroslavsky questioned if statistical reports were available in BreEZe.

Ms. Lowe stated that there are system reports that have been generated by the Department of Consumer Affairs that are still being validated, and some that are available in the system at this time. Also, Board staff have been creating reports in-house which has helped to obtain necessary data.

B. Licensing Statistics

Ms. Lowe provided an update on the licensing statistics and referred to Tab 9 of the packets. Ms. Lowe stated that the data reported was for the final quarter of fiscal year 2014/2015.

Ms. Yaroslavsky requested that for future meetings staff provide a breakdown of the numbers of licensed midwives in each license status for past years.

C. Enforcement Statistics

Ms. Lowe provided an update on the enforcement statistics and referred to the charts provided on page 33 of the meeting materials.

Ms. Yaroslavsky requested that for future meetings data related to licensed midwives and unlicensed midwives be separated into their own charts. Ms. Yaroslavsky added that the numbers should not be co-mingled as they do not have the same status, nor the same impact.

D. 2014 Licensed Midwife Annual Report

Ms. Lowe provided an update on the Licensed Midwife Annual Report (LMAR) and referred to the summary report provided on page 34 of the meeting materials. Ms. Lowe stated that the report reflects that 363 midwives were expected to report, and at the time that the report was compiled, July 20, 2015, there were 47 midwives who had not submitted their data. After July 20, 2015, five reports were received. Ms. Lowe stated that 13% of midwives had not submitted their reports. Of those that had not reported, it was found that 14 of them were in a current status practicing in California, two were in a current status with an address of record listed outside of California, and 14 were in delinquent status during the reporting period.

Ms. Yaroslavsky questioned if a letter had been sent to those midwives explaining that they will not be able to renew their license until they have submitted the LMAR.

Ms. Lowe stated that staff had not yet sent letters but would be doing so.

Ms. Lowe continued with the update referring to Section D, highlighting the number of clients served during the year. Ms. Lowe stated that 5,386 clients were served during 2014. In 2013, there were 5,052; in 2012 there were 4,370; in 2011 there were 3,934; and in 2010 there were 3,115. Between 2010 and 2014, the number of clients served increased from 3,115 to 5,386, which is 2,271 additional clients being served in California. Ms. Lowe added that not only has the number increased significantly, but at the end of 2014 there was also 1,282 clients that were still pending births.

Ms. Lowe stated that the report from 2010 reflected that 151 midwives provided care to 3,115 clients which means there are now 50 more midwives that are providing care in California and almost 2,500 more clients being served. Ms. Lowe referred to the section of the report regarding outcomes of out-of-hospital births and highlighted the 150 successful VBACs.

Ms. Yaroslavsky questioned for the 150 successful VBACs, if there was any data showing how many were planned or not planned?

Ms. Lowe stated that there was no additional data for VBACs currently. Ms. Lowe added that the number of successful VBACs was the only data currently being collected related to VBACs, which is one of the reasons for revising the LMAR.

Ms. Sparrevohn questioned if there was any way, without doing a regulation change, to revise the LMAR to exclude the midwife's address when utilizing OSHPD's online reporting system.

Ms. Lowe stated that since OSHPD has no reason to have that data, the address field will be removed next year.

Mr. Ackerman commented that when speaking of the difficulties of getting data from people who have not submitted it timely, it is MANA's experience, that the probability of ever obtaining the data drops down significantly with time. For that reason, MANA has set hard deadlines which seems to help. Mr. Ackerman stated that it was an interesting learning experience to see that deadlines seemed to actually be good for people. Mr. Ackerman stated that he understood that the Board could not make up their own deadlines, but was offering that information as a piece of advice.

Ms. Marceline questioned if the MANA statistics were collected nationally, and if so, would it be possible to divide out just California statistics.

Mr. Ackerman confirmed that it was possible and there were two approaches for that. One would be through a researcher, who might apply for access to the data and to perform their own study about California. Another would be through the California Association of Midwives (CAM), who has a state organization account that allows them to see the aggregate statistics for people who are listed as members of CAM.

Ms. Marceline questioned if midwives are not members of CAM if their data would be included.

Mr. Ackerman indicated that their data would not be included.

Ms. Gibson stated that there were no totals provided on numerous sections of the report and requested that the totals be listed in future reports.

Ms. Lowe indicated that there will be an enhancement to include the totals for the categories in the future.

Agenda Item 10 Presentation on Best Practices for Home to Hospital Transfers by Midwives

Ms. Holzer provided a presentation on the Best Practice Transfer Guidelines which included improved integration of services across birth sites for all women and families in the United States; stakeholder groups representing the complete spectrum of maternity care; the summit outcomes; and inter-professional collaboration and communication. Ms. Holzer provided an overview of why the Best Practice Guidelines: Transfer from Planned Home Birth to Hospital is needed; the Key Findings from the CDC; and the development process. Ms. Holzer concluded with the model practices for the midwife; the model practices for hospital provider and staff; and the quality improvement and policy development. A copy of the presentation was included in the meeting materials.

Agenda Item 11 **Agenda Items for the December 3, 2015 Midwifery Advisory Council Meeting in Sacramento**

- Report from the MAC Chair
- Update on LMAR Task Force
- Update on Midwifery Legislation
- Update on AB 1308
- Update on Midwifery Program

Agenda Item 12 **Adjournment**

Ms. Sparrevohn adjourned the meeting at 3:50 p.m.

The full meeting can be viewed at http://www.mbc.ca.gov/About_Us/Meetings/2015/