STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR

MEDICAL BOARD OF CALIFORNIA
1434 Howe Avenue, Suite 92, Sacramento, CA 95825
(916) 263-2389 Fax (916) 263-2387 www.mbc.ca.gov

MEMBERS OF THE COUNCIL

Faith Gibson, L.M., Chair
Ruth Haskins, M.D., Vice Chair
Karen Ehrlich, L.M.
Carrie Sparrevohn, L.M.
Guillermo Valenzuela, M.D.
Barbara Yaroslavsky

MIDWIFERY ADVISORY COUNCIL

September 6, 2007

Medical Board of California
Greg Gorges Conference Room
1424 Howe Avenue
Sacramento, CA 95825
(916) 263-2382

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

AGENDA

1:00 p.m. – 4 p.m.
(or until completion of business)

Members of the Board who are not members of the Council may be attending the meeting as observers.

1. Call to Order/Roll Call
2. Approval of Minutes of the June 12, 2007 Meeting
3. Midwife Annual Report Coding System
4. Midwife Annual Reporting Form and Instructions
5. Midwife Remedial/Re-entry to Practice Training Programs
6. Schedule of Future Meetings
7. Future Matters for Consideration by the Council
8. Public Comment on Items not on the Agenda
9. Adjournment

The mission of the Medical Board of California is to protect healthcare consumers through the proper licensing and regulation of physicians and surgeons and certain allied healthcare professions and through the vigorous, objective enforcement of the Medical Practice Act.

NOTICE: The meeting is accessible to the physically disabled. A person who needs disability-related accommodations or modifications to participate in the meeting shall make a request to the Board no later than five working days before the meeting by contacting Billie Baldo at (916) 263-2365 or sending a written request to Ms. Baldo at the Medical Board of California, 1426 Howe Avenue, Suite 54, Sacramento, CA 95825. Requests for further information should be directed to the same address and telephone number.

Meetings of the Midwifery Advisory Council are open to the public except when specifically noticed otherwise in accordance with the Open Meetings Act. The audience will be given appropriate opportunities to comment on any issue presented in open session before the Council, but the Chair may apportion available time among those who wish to speak.

****

For additional information, contact the Licensing Program at (916) 263-2382.

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR
MEDICAL BOARD OF CALIFORNIA – Division of Licensing
1428 Howe Avenue, Suite 56, Sacramento, CA 95825
(916) 263-2382 Fax (916) 263-2944 www.mbc.ca.gov

Midwifery Advisory Council

Greg Gorges Conference Room
1424 Howe Ave
Sacramento, CA 95825

June 12, 2007

MINUTES

Agenda Item 1 - Call to Order/Roll Call

The Midwifery Advisory Council of the Medical Board of California - Division of Licensing was called to order by Chair Faith Gibson at 1:07 p.m. A quorum was present and due notice had been mailed to all interested parties.

Members Present:
- Faith Gibson, LM, Chair
- Ruth Haskins, MD, Vice Chair
- Karen Ehrlich, LM
- Carrie Sparrevohn, LM
- Guillermo J. Valenzuela, MD
- Barbara Yaroslavsky

Staff Present:
- Billie Baldo, Administrative Assistant, Licensing Program
- Kathi Burns, Manager, Licensing Operations
- Kurt Heppler, Legal Counsel, Department of Consumer Affairs
- Scott Johnson, Business Services Assistant, Business Services Office
- Kimberly Kirchmeyer, Deputy Director
- Mike McCormick, Analyst, Licensing Operations
- Kelly Nelson, Analyst, Legislative/Regulatory Unit
- Gary Qualset, Chief, Licensing Program
- Kevin Schunke, Regulation Coordinator
- Anita Scuri, Legal Counsel, Department of Consumer Affairs
- Linda Whitney, Chief of Legislation

Members of the Audience:
- Claudia Breglia, California Association of Midwives (CAM)
- Frank Cuny, California Citizens for Health Freedom
- Laurie Gregg, MD, President, Division of Licensing
- Rachel Hansen, CAM
- Tosi Marceline, LM, CAM
- Alison Osborn, LM
- Robyn Strong, Analyst, Office of Statewide Health Planning and Development (OSHPD)

DRAFT

Agenda Item 2 – Approval of Minutes of the March 9, 2007 and April 17, 2007 Meetings

It was M/S/C (Haskins/Yaroslavsky) to approve the minutes of both the March 9, 2007 and April 17, 2007 meetings with minor amendments.

Agenda Item 3 – Role, Responsibility, Mission and Vision of Council

The members discussed their desire to have a statement that represents the council as a vehicle for licensed midwives to bring forth their issues to the Division of Licensing (division). Mr. Qualset emphasized that the council must work within their statutory authority and the direction provided by the division. He directed the council to their current vision statement as he felt it reflected their sentiment. After further review, the council agreed.

It was M/S/C (Ehrlich/Yaroslavsky) to approve the Role, Responsibility, Mission and Vision statements as amended.

Ms. Yaroslavsky inquired about the differences between the regulatory authority of licensed midwives, certified nurse-midwives, and lay midwives. The differences were discussed and it was noted that the Medical Board of California's (board's) regulatory authority extends only to those midwives (licensed midwives) licensed by the board.

Agenda Item 4 – Midwife Annual Report Coding System (Business and Professions Code Section 2516)

Discussion between MAC members, OSHPD representative Robyn Strong, individuals representing CAM and California Citizens for Health Freedom, public attendees, and division staff, resulted in amendments and definitions to further refine the Midwife Annual Report Coding System.

- It was M/S/C (Yaroslavsky/Ehrlich) to add "Clinical judgment of the midwife where a single other condition does not apply" to the Antepartum Transfer, Elective category.

Vote 5-1 (Opposed/Sparrevohn)

- It was M/S/C (Sparrevohn/Yaroslavsky) to categorize the mother and fetus as one (1) unit under the Antepartum and Intrapartum categories.

- It was M/S/C (Ehrlich/Yaroslavsky) to include the option of "Other" in all categories of the report.

- It was M/S/C (Ehrlich/Haskins) to add "Unstable lie or malposition of the vertex" to the Intrapartum Transfer, Elective category.

DRAFT

- It was M/S/C (Ehrlich/Haskins) to alter the Birth Outcomes After Transfer, Maternal category to include only the following options: 1) Vaginal birth at home with no complications; 2) Vaginal birth at home with episiotomy; 3) Vaginal birth in the hospital; 4) Cesarean delivery; and 5) Serious pregnancy/birth related medical complications not resolved by 6 weeks.

- It was M/S/C (Ehrlich/Haskins) to add to the Birth Outcomes After Transfer, Fetal/Neonatal category, 1) Birth related complications or birth injury not resolved by six (6) weeks; and 2) Healthy live born infant.

- It was M/S/C (Haskins/Valenzuela) to split "Non vertex lie at term, multiple gestation" into 1) Unstable lie or malposition of the vertex; and 2) Multiple gestation, under the Antepartum Transfer of Care, Elective category.

- It was M/S/C (Haskins/Valenzuela) to reconsider previous motions involving the Birth Outcomes After Transfer category.

- It was M/S/C (Sparrevohn/Haskins) to rescind the previous amendments to the Birth Outcomes After Transfer, Maternal category.

- It was M/S/C (Haskins/Valenzuela) to add 1) Vaginal birth with serious pregnancy/birth related medical complications not resolved by 6 weeks; 2) Vaginal birth with serious pregnancy/birth related medical complications resolved by 6 weeks; 3) Vaginal birth with infant death; 4) Cesarean delivery with serious pregnancy/birth related complications not resolved by 6 weeks; 5) Cesarean delivery with serious pregnancy/birth related medical complications resolved by 6 weeks; 6) Cesarean delivery with infant death; 7) Other, to the Birth Outcomes After Transfer, Maternal category.

- It was M/S/C (Ehrlich/Valenzuela) to add 1) Healthy live born infant; 2) Fetal demise diagnosed prior to labor; 3) Birth related medical complications or birth injury not resolved by 6 weeks; and 5) Other, to the Birth Outcomes After Transfer, Fetal/Neonatal category.

- It was M/S/C (Sparrevohn/Ehrlich) to strike "Birth related medical complications or birth injury not resolved by 6 weeks" from the Birth Outcomes After Transfer, Fetal/Neonatal category.

- It was M/S/C (Ehrlich/Haskins) that for the purposes of the coding system documents, "postpartum" is defined as "beginning as soon as the baby is born."

- It was M/S/C (Haskins/Ehrlich) to change 1) Anemia, persistent vomiting and dehydration, to Anemia; 2) Nutritional and weight loss issues, failure to gain weight, to Persistent vomiting with dehydration, nutritional, and weight loss issues; 3) Gestational diabetes, unable to control diet, to Gestational diabetes, under the Antepartum Transfer, Elective category.

- It was M/S/C (Sparrevohn/Haskins) to separate "Vaginal bleeding, suspected placental

DRAFT

implantation abnormalities" into 1) Vaginal bleeding; and 2) Placental anomalies or placental implantation abnormalities, under the Antepartum Transfer, Elective category.

- It was M/S/C (Sparrevohn/Haskins) to change "Miscarriage" and "Termination of pregnancy" to "Loss of pregnancy (includes spontaneous and elective abortion)" under the Antepartum Transfer, Elective category.

- It was M/S/C (Sparrevohn/Haskins) to strike "Preterm labor or preterm rupture of membranes" from the Antepartum Transfer, Elective category.

- It was M/S/C (Sparrevohn/Haskins) to change "Client request; request for pain relief" to "Client request" under the Intrapartum Transfer, Elective category.

- It was M/S/C (Sparrevohn/Haskins) to change "Adherent or retained placenta" under the Postpartum Transfer, Elective category to "Adherent or retained placenta without significant bleeding," and add "Adherent or retained placenta with significant bleeding" to the Postpartum Transfer, Urgent or Emergency category.

- It was M/S/C (Haskins/Ehrlich) to add "Thick meconium in the absence of fetal distress" to the Intrapartum Transfer, Elective category.

- It was M/S/C (Haskins/Sparrevohn) to change "Fetal heart tones irregularities, thick meconium," to "Thick meconium in the absence of fetal distress" in the Intrapartum Transfer/Elective category, and change "Fetal distress" to "Non-reassuring fetal heart tones" in the Intrapartum Transfer, Urgent or Emergent category.

- It was M/S/C (Sparrevohn, Haskins) to change "Persistent increase in blood pressure," to "Persistent hypertension; severe or persistent headache," under the Intrapartum Transfer, Elective category.

- It was M/S/C (Haskins/Sparrevohn) to strike the phrase "active labor true delivery of placenta" from the Intrapartum Transfers of Care (active labor true delivery of placenta) header.

- It was M/S/C (Haskins/Sparrevohn) to accept the following phrase as a precursor to the definitions, "The following definitions govern only the responses provided in this report."

- It was M/S/C (Sparrevohn/Haskins) to modify the language addressing group practice to: That in a group practice where all midwives share primary responsibility for all clients, the designation as to who the primary licensed midwife is for each client must be determined.

- It was M/S/C (Haskins/Sparrevohn) to approve the remaining four statements as true: 1) Collaborative care means the midwife received advice or client received additional medical care or advice regarding the pregnancy from a licensed physician or surgeon; 2) Under supervision

DRAFT

means: supervised by a licensed physician or surgeon who will go on record as being your supervisor for a particular case; 3) Non-medical reason means: client preference, relocation, insurance coverage issues, other inability to pay, lost to care; and 4) Intrapartum means the midwife has begun to monitor/attend woman in labor, regardless of cervical dilatation or contraction pattern.

- It was M/S/C (Ehrlich/Sparrevohn) to change "Signs of significant infection" to "Signs of infection" under the Postpartum Transfer, Elective category and change "Infection" to "Signs of significant infection" under the Postpartum Transfer, Urgent or Emergency category.

- It was M/S/C (Sparrevohn/Ehrlich) to strike "Pernicious vomiting" from the Neonatal Transfer of Care, Elective category.

- It was M/S/C (Haskins/Ehrlich) to modify "Congenital anomalies, birth injury, other medical conditions," to "Congenital anomalies, birth injury, other medical conditions of an emergent nature," and add "Significant cardiac or respiratory issues" and "Ten (10) minute APGAR score of less than seven (7)," to the Neonatal Transfer of Care, Urgent or Emergent category.

- It was M/S/C (Sparrevohn/Haskins) to strike "Abnormal bulging or depression of fontanel", and modify "Abnormal cry, seizures or loss of consciousness" to "Abnormal cry, seizures or loss of consciousness, or bulging of fontanels," and modify "Significant dehydration" to "Significant dehydration or depression of fontanels," under the Neonatal Transfer of Care, Urgent or Emergent category.

Agenda Item 5 – Midwifery Assessment and Clinical Evaluation Discussion

In October 2006, the division discussed the topic of midwife assessment and clinical evaluation. The division directed the council to explore the feasibility of developing or identifying a program to address remedial training as an option for disciplinary resolution or re-entry to practice after a long absence for licensed midwives. Ms. Sparrevohn suggested separating the topics into two separate areas, one being remedial training and the other being re-entry to practice. It was asked that staff research the items for further discussion at the next meeting.

It was M/S/C (Sparrevohn/Haskins) to have staff research remedial training and re-entry to practice options for licensed midwives and bring information back to the next council meeting.

Agenda Item 6 – Public Comment on Items not on the Agenda

None.

Agenda Item 7 - Adjournment

The meeting adjourned at 4:50 p.m.

DRAFT

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR
MEDICAL BOARD OF CALIFORNIA – DIVISION OF LICENSING
1428 Howe Avenue, Suite 56, Sacramento, CA 95825-3204
Telephone (916) 263-2382 Fax (916) 263-2487 www.mbc.ca.gov

MEMORANDUM

DATE	August 10, 2007
TO	Members, Midwifery Advisory Council
FROM	Kathi Burns, Manager KB Licensing Operations Section
SUBJECT	**Midwife Annual Report Coding System**

Attached is the most recent version of the Midwife Annual Report Coding System. This document was created based upon input from the Midwifery Advisory Council (MAC); Office of Statewide Health Planning and Development staff; and Division of Licensing staff.

Please review this document in its entirety and make note of any questions, concerns, or suggestions you may have for discussion at the September 6, 2007, MAC meeting. Pay particular attention to the highlighted areas as they represent a significant change from the prior version of this document. Time during the meeting does not allow for a line by line review of this document, so please be prepared to bring forth your identified issues for discussion.

If you have any questions regarding this document, please contact me at (916) 263-2417 or kburns@mbc.ca.gov.

Attachments:
Business and Professions Code Section 2516
Midwife Annual Report Coding System

Section 2516 – Report on out-of-hospital births to be submitted annually; Confidentiality; Noncompliance

2516. (a) Each licensed midwife who assists, or supervises a student midwife in assisting, in childbirth that occurs in an out-of-hospital setting shall annually report to the Office of Statewide Health Planning and Development. The report shall be submitted in March, with the first report due in March 2008, for the prior calendar year, in a form specified by the board and shall contain all of the following:

(1) The midwife's name and license number.

(2) The calendar year being reported.

(3) The following information with regard to cases in which the midwife, or the student midwife supervised by the midwife, assisted in the previous year when the intended place of birth at the onset of care was an out-of-hospital setting:

(A) The total number of clients served as primary caregiver at the onset of care.

(B) The total number of clients served with collaborative care available through, or given by, a licensed physician and surgeon.

(C) The total number of clients served under the supervision of a licensed physician and surgeon.

(D) The number by county of live births attended as primary caregiver.

(E) The number, by county, of cases of fetal demise attended as primary caregiver at the discovery of the demise.

(F) The number of women whose primary care was transferred to another health care practitioner during the antepartum period, and the reason for each transfer.

(G) The number, reason, and outcome for each elective hospital transfer during the intrapartum or postpartum period.

(H) The number, reason, and outcome for each urgent or emergency transport of an expectant mother in the antepartum period.

(I) The number, reason, and outcome for each urgent or emergency transport of an infant or mother during the intrapartum or immediate postpartum period.

(J) The number of planned out-of-hospital births at the onset of labor and the number of births completed in an out-of-hospital setting.

(K) The number of planned out-of-hospital births completed in an out-of-hospital setting that were any of the following:

(i) Twin births.

(ii) Multiple births other than twin births.

(iii) Breech births.

(iv) Vaginal births after the performance of a caesarian section.

(L) A brief description of any complications resulting in the mortality of a mother or an infant.

(M) Any other information prescribed by the board in regulations.

(b) The Office of Statewide Health Planning and Development shall maintain the confidentiality of the information submitted pursuant to this section, and shall not permit any law enforcement or regulatory agency to inspect or have copies made of the contents of any reports submitted pursuant to subdivision (a) for any purpose, including, but not limited to, investigations for licensing, certification, or regulatory purposes.

(c) The office shall report to the board, by April, those licensees who have met the requirements of subdivision (a) for that year.

(d) The board shall send a written notice of noncompliance to each licensee who fails to meet the reporting requirement of subdivision (a). Failure to comply with subdivision (a) will result in the midwife being unable to renew his or her license without first submitting the requisite data to the Office of Statewide Health Planning and Development for the year for which that data was missing or incomplete. The board shall not take any other action against the licensee for failure to comply with subdivision (a).

(e) The board, in consultation with the office and the Midwifery Advisory Council, shall devise a coding system related to data elements that require coding in order to assist in both effective reporting and the aggregation of data pursuant to subdivision (f).

The office shall utilize this coding system in its processing of information collected for purposes of subdivision (f).

(f) The office shall report the aggregate information collected pursuant to this section to the board by July of each year. The board shall include this information in its annual report to the Legislature.

(g) Notwithstanding any other provision of law, a violation of this section shall not be a crime.

Midwife Annual Report
CODING SYSTEM

Antepartum Transfer of Care

Elective:

AE1 Medical or mental health conditions *unrelated* to pregnancy
AE2 Hypertension developed in pregnancy
AE3 Blood coagulation disorders, including phlebitis
AE4 Anemia
AE5 Persistent vomiting with dehydration
AE6 Nutritional & weight loss issues, failure to gain weight
AE7 Gestational diabetes
AE8 Vaginal bleeding
AE9 Placental anomalies or implantation abnormalities
AE10 Loss of pregnancy (includes spontaneous and elective abortion)
AE11 HIV test positive
AE12 Intrauterine growth restriction, fetal anomalies
AE13 Abnormal amniotic fluid volumes; oligohydramnios or polyhydramnios
AE14 Intrauterine growth restriction, (IUGR), fetal anomalies
AE15 Fetal heart irregularities
AE16 Non vertex lie at term
AE17 Multiple gestation
AE18 Clinical judgment of the midwife (where a single other condition above does not apply)
AE19 Client request
AE20 Non-medical reason
AE21 Other

Urgent or Emergent:

AU1 Non pregnancy-related medical condition
AU2 Severe or persistent headache, pregnancy-induced hypertension (PIH) or preeclampsia
AU3 Isoimmunization, severe anemia, or other blood related issues
AU4 Significant infection
AU5 Significant vaginal bleeding
AU6 Preterm labor or preterm rupture of membranes
AU7 Marked decrease in fetal movement, abnormal fetal heart tones, non-reassuring non-stress test (NST)
AU8 Fetal demise
AU9 Clinical judgment of the midwife (where a single other condition above does not apply)
AU10 Other

DRAFT

Intrapartum Transfer of Care

Elective:

IE1 Persistent hypertension; severe or persistent headache
IE2 Active herpes lesion
IE3 Abnormal bleeding
IE4 Signs of infection
IE5 Prolonged rupture of membranes
IE6 Lack of progress; maternal exhaustion; dehydration
IE7 Thick meconium in the absence of fetal distress
IE8 Non-vertex presentation
IE9 Unstable lie or mal-position of the vertex
IE10 Multiple gestation, not diagnosed prior to labor
IE11 Clinical judgment of the midwife (where a single other condition above does not apply)
IE12 Client request; request for medical methods of pain relief
IE13 Other

Comment [KB1]: Confirm wording, also should "Thick meconium be added to Urgent/Emergent Section?

Comment [KB2]: Proposed wording addition.

Urgent/Emergent:

IU1 Preeclampsia, eclampsia, seizures
IU2 Significant vaginal bleeding including suspected placental abruption with severe abdominal pain inconsistent with normal labor
IU3 Uterine rupture
IU4 Maternal shock, loss of consciousness
IU5 Prolapsed umbilical cord
IU6 Non-reassuring fetal heart tones
IU7 Clinical judgment of the midwife (where a single other condition above does not apply)
IU8 Other life threatening conditions or symptoms

DRAFT

Postpartum Transfer of Care

Elective:

PE1 Adherent or retained placenta without significant bleeding
PE2 Repair of laceration beyond level of midwife's expertise
PE3 Postpartum depression
PE4 Social, emotional or physical conditions outside of scope of practice
PE5 Excessive or prolonged bleeding in later postpartum period
PE6 Signs of infection
PE7 Clinical judgment of the midwife (where a single other condition above does not apply)
PE8 Client request
PE9 Other

Urgent or Emergency:

PU1 Abnormal or unstable vital signs
PU2 Uterine inversion, rupture or prolapse
PU3 Uncontrolled hemorrhage
PU4 Seizures or unconsciousness, shock
PU5 Adherent or retained placenta with significant bleeding
PU6 Postpartum psychosis
PU7 Signs of significant infections
PU8 Clinical judgment of the midwife (where a single other condition above does not apply)
PU9 Other

Neonatal Transfer of Care

Elective:

NE1 Low birth weight
NE2 Congenital anomalies, birth injury
NE3 Poor transition to extrauterine life
NE4 Insufficient passage of urine or meconium
NE5 Parental request
NE6 Clinical judgment of the midwife (where a single other condition above does not apply)
NE7 Other medical conditions

Urgent or Emergent:

NU1 Abnormal vital signs or color, poor tone, lethargy, no interest in nursing
NU2 Signs or symptoms of infection
NU3 Abnormal cry, seizures or loss of consciousness
NU4 Significant jaundice at birth or within 30 hours
NU5 Evidence of clinically significant prematurity
NU6 Congenital anomalies, birth injury, other medical conditions of an emergent nature
NU7 Significant cries, seizures, or loss of consciousness
NU8 Significant dehydration or depression of fontanels
NU9 Significant cardiac or respiratory issues
NU10 Ten minute APGAR of less than seven (7)
NU11 Abnormal bulging of fontanel
NU12 Other

Complications Leading to Maternal/Infant Mortality

Related to Mother:

CM1 Blood loss
CM2 Sepsis
CM3 Eclampsia/toxemia or HELLP syndrome
CM4 Embolism (pulmonary or amniotic fluid)
CM5 Other

DRAFT

Related to Infant:

CI1 Infection
CI2 Anomaly incompatible with life
CI3 Meconium aspiration, other respiratory issues
CI4 Neurological issues/seizures
CI5 Other medical issue
CI6 Unknown
CI7 Other

Birth Outcomes After Transfer

Relating to Mother:

Vaginal:	Caesarian:	
OM1	OM6	Without complication
OM2	OM7	With serious pregnancy/birth related medical complications not resolved by 6 weeks
OM3	OM8	With serious pregnancy/birth related medical complications resolved by 6 weeks
OM4	OM9	Death of mother
OM5	OM10	Other

Relating to Infant/Fetus:

Vaginal:	Caesarian:	
OI1	OI7	Healthy live born infant
OI2	OI8	Fetal demise diagnosed prior to labor
OI3	OI9	Fetal demise diagnosed during labor or at delivery
OI4	OI10	With serious pregnancy/birth related medical complications not resolved by 6 weeks
OI5	OI11	With serious pregnancy/birth related medical complications resolved by 6 weeks
OI6	OI12	Live born infant who subsequently died
OI7	OI13	Other

Comment [KB3]: 3 proposed additions to category.

DRAFT

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR
MEDICAL BOARD OF CALIFORNIA – DIVISION OF LICENSING
1428 Howe Avenue, Suite 56, Sacramento, CA 95825-3204
Telephone (916) 263-2382 Fax (916) 263-2487 www.mbc.ca.gov

MEMORANDUM

DATE	August 14, 2007
TO	Members, Midwifery Advisory Council
FROM	Kathi Burns, Manager KB Licensing Operations Section
SUBJECT	**Midwife Annual Reporting Form and Instructions**

Attached are the most recent versions of the Midwife Annual Reporting Form and Instructions. These documents were created based upon input from the Midwifery Advisory Council (MAC); Office of Statewide Health Planning and Development staff; and Division of Licensing staff.

Please review these documents in their entirety and make note of any questions, concerns, or suggestions you may have for discussion at the September 6, 2007, MAC meeting. Pay particular attention to the highlighted areas as they represent a significant change from the prior versions of these documents. Time during the meeting does not allow for a line by line review of these documents, so please be prepared to bring forth your identified issues for discussion.

If you have any questions regarding these documents, please contact me at (916) 263-2417 or kburns@mbc.ca.gov.

Attachments:
Midwife Annual Reporting Form and Instructions

INSTRUCTIONS FOR COMPLETING

THE LICENSED MIDWIFE ANNUAL REPORT

Pursuant to Business and Professions Code section 2516, all licensed midwives must report specific information related to birthing services provided when the client's intended place of birth at the onset of care is an out-of-hospital setting. The attached form has been developed to allow for such reporting. Please consult these instructions while completing the form to ensure that the proper information is reported.

Please note that the form is to be submitted to the Office of Statewide Health Planning and Development (OSHPD) not the Medical Board of California (board). The OSHPD will report the data collected, in aggregate form, to the board each year. Your identity will remain confidential. Only the identity of those licensed midwives who fail to file a report with the OSHPD will be reported to the board for purposes of restricting license renewal until a report is received.

DEFINITIONS:

(The following definitions govern only the responses provided in this report)

Primary Care Giver – Licensed midwife contracted by client to provide primary care midwifery services during her pregnancy and/or out-of-hospital delivery.

If services are provided in a practice or medical group type setting, one licensed midwife must be deemed to be the primary care giver for each client for reporting purposes. This determination may be made in a variety of ways. For example, the primary care giver is the licensed midwife who, a) meets the client first, b) does the client intake, c) delivers the infant, etc…

Collaborative Care – Midwife receives advice or client receives additional medical care or advice regarding the pregnancy from a licensed physician or surgeon.

Supervision – Midwife is supervised by a licensed physician or surgeon who will go on record as being the midwife's supervisor for a particular case.

Non-medical Reason – Client preference, relocation, insurance issues, other inability to pay, lost to care/unknown.

Intrapartum – Midwife has begun to monitor/attend woman in labor, regardless of cervical dilation or contraction pattern.

Postpartum – After infant has been born.

Comment [KB1]: Changed from "baby" for wording consistency.

Healthcare Provider – Includes an individual practitioner (other than a licensed midwife) or medical facility.

Comment [KB2]: Added definition.

DRAFT

Section A – LICENSEE DATA

You must provide your name and your California Licensed Midwife License number. All other information in this section is voluntary; however, it will assist the OSHPD in contacting you should questions relating to your survey arise.

Section B – REPORTING PERIOD

Indicate the calendar year for which this report pertains.

Section C – SERVICES PROVIDED

Line 12 –

If the answer is "no," because no qualifying services were performed during the year, skip all further questions and go to the last page. Sign and date the form and mail it to:

Office of Statewide Health Planning and Development
Patient Data Section
Licensed Midwife Annual Report
400 R Street, Suite 2100
Sacramento, CA 95811

SUBMIT A REPORT - EVEN IF NO QUALIFYING SERVICES WERE PERFORMED: Pursuant to Business and Professions Code section 2516(d), failure to submit this report to the OSHPD will delay the renewal of your midwife license until receipt of the report. For questions concerning this report, you may contact OSHPD at (916) 323-7679 or the Medical Board of California at (916) 263-2382.

If the answer is "yes," proceed to the next section.

Section D – CLIENT SERVICES

Line 13 – Enter the total number of clients (include any client, regardless of year initially booked) you provided midwifery services to in this reporting year, as the primary care giver *whose intended place of birth at* ***the onset of care*** was an out-of-hospital setting. This includes clients who may have left your care at some point for a non-medical reason and clients where collaborative care or supervision occurred. If there were none, enter zero (0) and submit the form as described above in Section C.

Comment [KB3]: At this point, tracking each birth seems arduous for the reporter, as the client booking and birth often occur in different fiscal years. We may reconsider this when the reporting format becomes electronic. This will be reflected in the aggregated data.

Line 14 – Enter the total number of clients (include any client, regardless of year initially booked) who left care for non-medical reasons rather than being transferred to another provider. If there were none, enter zero (0).

Line 15 – Enter the total number of clients (regardless of year initially booked) who were pending on the last day of this reporting year (i.e. those who have yet to give birth).

Comment [KB4]: New question added. This may help identify number of clients served, births that occurred, and births outstanding to better clarify the statistics. This will be reflected in the aggregated data.

DRAFT

Line 16 – Enter the total number of clients you served (regardless of year initially booked) *when the intended place of birth at the* ***onset of care*** was an out-of-hospital setting and who also received collaborative care.

Line 17 – Enter the total number of clients you served (regardless of year initially booked) under the supervision of a licensed physician and surgeon *when the intended place of birth at the* ***onset of care*** was an out-of-hospital setting.

Section E – OUTCOMES OF ATTENDED BIRTHS

Include all births that occurred during this reporting year, regardless of year client was initially booked.

Lines 18(a-g)– In **Column A**, enter each county (using the county codes listed below) where you attended a birth as the primary caregiver.
– In **Column B**, enter the actual number of live births attended as primary care giver.
– In **Column C**, indicate the number of births attended as primary care giver where the fetus died.

County Codes:

1	Alameda	21	Marin	41	San Mateo
2	Alpine	22	Mariposa	42	Santa Barbara
3	Amador	23	Mendocino	43	Santa Clara
4	Butte	24	Merced	44	Santa Cruz
5	Calaveras	25	Modoc	45	Shasta
6	Colusa	26	Mono	46	Sierra
7	Contra Costa	27	Monterey	47	Siskiyou
8	Del Norte	28	Napa	48	Solano
9	El Dorado	29	Nevada	49	Sonoma
10	Fresno	30	Orange	50	Stanislaus
11	Glenn	31	Placer	51	Sutter
12	Humboldt	32	Plumas	52	Tehama
13	Imperial	33	Riverside	53	Trinity
14	Inyo	34	Sacramento	54	Tuolumne
15	Kern	35	San Benito	55	Tulare
16	Kings	36	San Bernardino	56	Ventura
17	Lake	37	San Diego	57	Yolo
18	Lassen	38	San Francisco	58	Yuba
19	Los Angeles	39	San Joaquin	59	Out-of-state
20	Madera	40	San Luis Obispo		

Section F – OUTCOME FOR OUT-OF-HOSPITAL BIRTHS

Include all births that occurred during this reporting year, regardless of year client was initially booked. (It is understood that for this section each birth experience or infant born may be included on one or more lines.)

Line 19 – In column A, enter the total number of out-of-hospital births you planned on attending as the primary care giver ***at the onset of labor.***

Line 20 – Out of the total number of out-of-hospital births you planned on attending as the primary care giver ***at the onset of labor*** (as indicated in line 19), enter, in column A the number of those births that actually did occur in an out-of-hospital setting.

DRAFT

Lines 21 and 22 – Enter the number of planned births you attended (in an out-of-hospital setting) as the primary care giver that involved twins and multiple births. Include the number of actual infants delivered in Column A and the number of sets of twins or multiples in Column B. (Multiples are births involving more than two infants).

Lines 23 and 24 – In column A, enter the number of births you attended as the primary care giver that were breech births and/or (during the prior pregnancy) vaginal births after the performance of a caesarian section (VBAC). For these lines count each infant delivered.

Comment [KB5]: Is this correct? Or, should it be during "any" prior pregnancy? Or, does it even need to be here?

FOR THE REMAINING SECTIONS
CHOOSE ONE CATEGORY THAT BEST FITS EACH CLIENT TRANSFER

Section G – ANTEPARTUM TRANSFER OF CARE, ELECTIVE

Lines 25- 45 – For each reason listed, enter the number of clients who, during the antepartum period, were voluntarily (no emergency existed) transferred to the care of another healthcare provider. Choose only one reason for each client.

Section H – ANTEPARTUM TRANSFER OF CARE, URGENT/EMERGENCY

Lines 46-55 – For each reason listed, enter the number of clients who, during the antepartum period, were transferred to the care of another healthcare provider due to an urgent or emergency situation. Choose only one reason for each client.

Section I – INTRAPARTUM TRANSFER OF CARE, ELECTIVE

Lines 56-68 – For each reason listed, enter the number of clients who, during the intrapartum period, were voluntarily (no emergency existed) transferred to the care of another healthcare provider. Choose only one reason for each client.

Section J – INTRAPARTUM TRANSFER OF CARE, URGENT/EMERGENCY

Lines 69-76 – For each reason listed, enter the number of clients who, during the intrapartum period, were transferred to the care of another healthcare provider due to an urgent or emergency situation. Choose only one reason for each client.

Section K – POSTPARTUM TRANSFER OF CARE, ELECTIVE

Lines 77-85 – For each reason listed, enter the number of clients who, during the postpartum period, were voluntarily (no emergency existed) transferred to the care of another healthcare provider. Choose only one reason for each client.

Section L – POSTPARTUM TRANSFER OF CARE, URGENT/EMERGENCY

Lines 86-94 – For each reason listed, enter the number of clients who, during the postpartum period, were transferred to the care of another healthcare provider due to an urgent or emergency situation. Choose only one reason for each client.

Section M – NEONATAL TRANSFER OF CARE, ELECTIVE

Lines 95-101 – For each reason listed, enter the number of infants who were voluntarily (no emergency existed) transferred to the care of another healthcare provider. Choose only one reason for each infant.

Section N – NEONATAL TRANSFER, URGENT/EMERGENCY

Lines 102-113 – For each reason listed, enter the number of infants who were transferred to the care of another healthcare provider due to an urgent or emergency situation. Choose only one reason for each infant.

Section O – COMPLICATIONS LEADING TO MORTALITY

Lines 114-118 – For each complication listed, enter the number of mothers who died during the pregnancy or within the first 42 days after termination of a pregnancy, as a result of that complication. Choose only one complication for each client.

Comment [KB6]: This is part of the definition of maternal death from the World Health Organization. Do you want this wording added?

Lines 119-125 – For each complication listed, enter the number of infants who were live born and subsequently died within the first 42 days after birth as a result of that complication. Choose only one complication for each client.

Comment [KB7]: This is part of the definition of maternal death from the World Health Organization. Do you want this wording added?

Section P – BIRTH OUTCOMES AFTER TRANSFER OF CARE

Lines 126-130 – For births occurring after the transfer of care of the mother or infant (from the licensed midwife to that of another healthcare provider) for urgent reasons in the antepartum period, or for any reason in the intrapartum or postpartum periods, indicate whether the birth was vaginal or caesarian by using columns A or B for each outcome listed as it pertains to the mother.

Lines 131-137 – For births occurring after the transfer of care of the mother and infant (from the licensed midwife to that of another healthcare provider), indicate whether the birth was vaginal or caesarian by using columns A or B for each outcome listed as it pertains to the infant.

DRAFT

CALIFORNIA LICENSED MIDWIFE ANNUAL REPORT

Completion/submission of this form by all licensed midwives in California is required pursuant to Business and Professions Code section 2516(c). Your midwife license will not be renewed unless and the requisite data is submitted.

SECTION A – LICENSEE DATA

1. Midwife Name	1a. First:	1b. Middle:	1c. Last:
2. License Number	☐☐☐☐☐		
3. Street Address 1			
4. Street Address 2			
5. City:		6. State:	7. Zip:
8. Phone 1: ☐☐☐-☐☐☐-☐☐☐☐		9. Phone 2: ☐☐☐-☐☐☐-☐☐☐☐	
10. E-mail Address:			

SECTION B – REPORTING PERIOD

Line no.	Report Year
11	☐☐☐☐

SECTION C – SERVICES PROVIDED

Line No.		Yes	No*
12	Did you, or a student midwife supervised by you, perform midwife services during the year when the intended place of birth at the onset of care was an out-of-hospital setting?		
	***If you answered no, go to the last page, sign and date the report and mail it to:** Office of Statewide Health Planning and Development Patient Data Section Licensed Midwife Annual Report 400 R Street, Suite 2100 Sacramento, CA 95811		

DRAFT

License Number	

SECTION D – CLIENT SERVICES

Line No.		Total #
13	Number of clients you served as primary care giver whose intended place of birth, at the onset of care, was an out-of-hospital setting	
14	Number of clients you served as primary care giver whose intended place of birth, at the onset of care, was an out-of-hospital setting and who left care for a non-medical reason	
15	Number of clients pending on the last day of this reporting year	
16	Number of clients you served who received collaborative care	
17	Number of clients you served while you were under the supervision of a licensed physician and surgeon	

Comment [KB1]: New question-see instructions for further information.

SECTION E - OUTCOMES OF ATTENDED BIRTHS

Line No.	(A) County (see instructions for county code list)	(B) # of Live Births	(C) # of Cases Fetal Demise
18a			
18b			
18c			
18d			
18e			
18f			
18g			

DRAFT

SECTION F – OUTCOMES OF OUT-OF-HOSPITAL BIRTHS

Line No.		(A) Total #	(B) # of Sets
19	Number of planned out-of-hospital births at the onset of **labor**		
20	Number of completed births		
21	Twins		
22	Multiples (Other than twin births)		
23	Breech		
24	VBAC		

SECTION G – ANTEPARTUM TRANSFER OF CARE, ELECTIVE

License Number	

Line No.	Code	Reason	Total #
25	AE1	Medical or mental health conditions *unrelated* to pregnancy	
26	AE2	Hypertension developed in pregnancy	
27	AE3	Blood coagulation disorders, including phlebitis	
28	AE4	Anemia	
29	AE5	Persistent vomiting with dehydration	
30	AE6	Nutritional & weight loss issues, failure to gain weight	
31	AE7	Gestational diabetes	
32	AE8	Vaginal bleeding	
33	AE9	Placental anomalies or implantation abnormalities	
34	AE10	Loss of pregnancy (includes spontaneous and elective abortion)	
35	AE11	HIV test positive	
36	AE12	Intrauterine growth restriction, fetal anomalies	
37	AE13	Abnormal amniotic fluid volumes; oligohydramnios or polyhydramnios	
38	AE14	Intrauterine growth restriction (IUGR), fetal anomalies	
39	AE15	Fetal heart irregularities	
40	AE16	Non vertex lie at term	
41	AE 17	Multiple gestation	
42	AE18	Clinical judgment of the midwife (where a single other condition above does not apply)	
43	AE19	Client request	
44	AE20	Non-medical reason	
45	AE21	Other	

DRAFT

SECTION H – ANTEPARTUM TRANSFER OF CARE, URGENT/EMERGENCY

Line No.	Code	Reason	Total #
46	AU1	Non pregnancy-related medical condition	
47	AU2	Severe or persistent headache, pregnancy-induced hypertension (PIH), or preeclampsia	
48	AU3	Isoimmunization, severe anemia, or other blood related issues	
49	AU4	Significant infection	
50	AU5	Significant vaginal bleeding	
51	AU6	Preterm labor or preterm rupture of membranes	
		(reasons continue on next page)	
52	AU7	Marked decrease in fetal movement, abnormal fetal	

License Number	

		heart tones, non-reassuring non-stress test (NST)	
53	AU8	Fetal demise	
54	AU9	Clinical judgment of the midwife (where a single other condition above does not apply)	
55	AU10	Other	

SECTION I – INTRAPARTUM TRANSFER OF CARE, ELECTIVE

Line No.	Code	Reason	Total #
56	IE1	Persistent hypertension; severe or persistent headache	
57	IE2	Active herpes lesion	
58	IE3	Abnormal bleeding	
59	IE4	Signs of infection	
60	IE5	Prolonged rupture of membranes	
61	IE6	Lack of progress; maternal exhaustion; dehydration	
62	IE7	Thick meconium in the absence of fetal distress	
63	IE8	Non-vertex presentation	
64	IE9	Unstable lie or mal-position of the vertex	
65	IE10	Multiple gestation, not diagnoses prior to labor	
66	IE11	Clinical judgment of the midwife (where a single other condition above does not apply)	
67	IE12	Client request; request for medical methods of pain relief	
68	IE13	Other	

SECTION J – INTRAPARTUM TRANSFER OF CARE, URGENT/EMERGENCY

Line No.	Code	Reason	Total #
69	IU1	Preeclampsia, eclampsia, seizures	
70	IU2	Significant vaginal bleeding including suspected placental abruption with severe abdominal pain inconsistent with normal labor	
71	IU3	Uterine rupture	
72	IU4	Maternal shock, loss of consciousness	
73	IU5	Prolapsed umbilical cord	
74	IU6	Non-reassuring fetal heart tones	
75	IU7	Clinical judgment of the midwife (where a single other condition above does not apply)	
76	IU8	Other life threatening conditions or symptoms	

SECTION K – POSTPARTUM TRANSFER OF CARE, ELECTIVE

DRAFT

License Number	

Line No.	Code	Reason	Total #
77	PE1	Adherent or retained placenta without significant bleeding	
78	PE2	Repair of laceration beyond level of midwife's expertise	
79	PE3	Postpartum depression	
80	PE4	Social, emotional or physical conditions outside of scope of practice	
81	PE5	Excessive or prolonged bleeding in later postpartum period	
82	PE6	Signs of infection	
83	PE7	Clinical judgment of the midwife (where a single other condition above does not apply)	
84	PE8	Client request	
85	PE9	Other	

SECTION L – POSTPARTUM TRANSFER OF CARE, URGENT/EMERGENCY

Line No.	Code	Reason	Total #
86	PU1	Abnormal or unstable vital signs	
87	PU2	Uterine inversion, rupture or prolapse	
88	PU3	Uncontrolled hemorrhage	
89	PU4	Seizures or unconsciousness, shock	
90	PU5	Adherent or retained placenta with significant bleeding	
91	PU6	Postpartum psychosis	
92	PU7	Signs of significant infections	
93	PU8	Clinical judgment of the midwife (where a single other condition above does not apply)	
94	PU9	Other	

SECTION M – INFANT TRANSFER OF CARE, ELECTIVE

Comment [KB2]: Changed from Neonatal for wording consistency.

Line No.	Code	Reason	Total #
95	NE1	Low birth weight	
96	NE2	Congenital anomalies, birth injury	
97	NE3	Poor transition to extrauterine life	
98	NE4	Insufficient passage of urine or meconium	
99	NE5	Parental request	
100	NE6	Clinical judgment of the midwife (where a single other condition above does not apply)	
101	NE7	Other medical conditions	

DRAFT

License Number	

SECTION N – INFANT TRANSFER OF CARE, URGENT/EMERGENCY

Comment [KB3]: Changed from Neonatal for wording consistency.

Line No.	Code	Reason	Total #
102	NU1	Abnormal vital signs or color, poor tone, lethargy, no interest in nursing	
103	NU2	Signs or symptoms of infection	
104	NU3	Abnormal cry, seizures or loss of consciousness	
105	NU4	Significant jaundice at birth or within 30 hours	
106	NU5	Evidence of clinically significant prematurity	
107	NU6	Congenital anomalies, birth injury, other medical conditions of an emergent nature	
108	NU7	Significant cries, seizures, or loss of consciousness	
109	NU8	Significant dehydration or depression of fontanels	
110	NU9	Significant cardiac of respiratory issues	
111	NU10	Ten minute APGAR of less than seven (7)	
112	NU11	Abnormal bulging of fontanel	
111	NU12	Other	

SECTION O – COMPLICATIONS LEADING TO MATERNAL/INFANT MORTALITY

Line No.	Code	Complication	Total #
MOTHER			
114	CM1	Blood loss	
115	CM2	Sepsis	
116	CM3	Eclampsia/toxemia or HELLP syndrome	
117	CM4	Embolism (pulmonary or amniotic fluid)	
118	CM5	Other	
INFANT			
119	CI1	Infection	
120	CI2	Anomaly incompatible with life	
121	CI3	Meconium aspiration, other respiratory issues	
122	CI4	Neurological issues/seizures	
123	CI5	Other medical issue	
124	CI6	Unknown	
125	CI7	Other	

SECTION P – BIRTH OUTCOMES AFTER TRANSFER

DRAFT

License Number	

Line No.	Reason	(A) Total # of Vaginal Births		(B) Total # of Caesarian Deliveries	
MOTHER					
126	Without complication	OM1		OM6	
127	With serious pregnancy/birth related medical complications not resolved by 6 weeks	OM2		OM7	
128	With serious pregnancy/birth related medical complications resolved by 6 weeks	OM3		OM8	
129	Death of mother	OM4		OM9	
130	Other	OM5		OM10	
INFANT/FETUS					
131	Healthy live born infant	OI1		OI6	
132	Fetal demise diagnosed prior to labor	OI2		OI8	
133	Fetal demise diagnosed during labor or at delivery	OI3		OI9	
134	With serious pregnancy/birth related medical complications not resolved by 6 weeks	OI4		OI10	
135	With serious pregnancy/birth related medical complications resolved by 6 weeks	OI5		OI11	
136	Live born infant who subsequently died	OI6		OI12	
137	Other	OI7		OI13	

DRAFT

Signature

Date

Printed Name

State of California

Department of Consumer Affairs
Medical Board of California

Memorandum

To : Members, Midwifery Committee

Date: October 13, 2006

From : Herman Hill, Analyst
Licensing Operations

Subject : **Feasibility Discussion – Midwifery Assessment and Clinical Education Program Implementation**

Issue:

During discussions that occurred at the DOL Meeting on May 11-12, 2006, Dr. Richard Fantozzi, President, Division of Licensing, directed that licensing staff investigate the feasibility of implementing a Midwifery "re-entry/retraining" program. As this discussion unfolded, there was concern regarding how the Midwifery Education Accreditation Council (MEAC) and the midwifery community at-large handle this issue. Other issues that emerged as a result of this discussion included:

- Determining whether any re-entry programs are operating nationwide and within the profession of midwifery; and
- What happens to midwives who have been out of practice for a period of time (not specified) and wants to come back to the profession.

Background:

The search for information relative to this issue began with conducting an interview with Mary Ann Baul, Executive Director, Midwifery Education Accreditation Council (MEAC). This agency is one of several "directly supporting" agencies of California's Licensed Midwife Program. Other equally supportive agencies will also be discussed as it relates to information pertinent to midwifery re-entry/retraining programs.

Midwifery Education Accreditation Council (MEAC)

The purpose of MEAC is to establish standards for the education of competent midwives and to provide a process for self-evaluation and peer evaluation for diverse education programs. The U.S. Secretary of Education has listed MEAC as a nationally recognized accrediting agency for post secondary midwifery education programs. MEAC's responsibilities are directly related to midwifery education programs (schools) and not to developing, maintaining, or evaluating possible reentry or similar programs, if they currently exist. For this reason, MEAC should not be expected to and has fundamentally declined to provide a framework for any retraining, re-entry, or rehabilitative programs that may be a result of this administrative inquiry. During previous assessments of midwifery education programs, none were found to have implemented re-entry or retraining programs for midwives.

North American Registry of Midwives (NARM)

The subject of existing reentry programs for midwives was posed to NARM (Ida Darraugh, Director of Testing). The director's response indicated that there was no specifically designed 're-entry" programs monitored or administered by NARM. However, the director indicated that NARM had received a recent request from the state of Florida to allow one candidate to retake the NARM Certification examination because she had not been in practice for a few years but meets the requirements for licensing in Florida. The NARM examination has not been redesigned to address this particular situation.

The director further discussed that each state has different regulations regarding re-entry. Licensing staff's review of Utah, Virginia, and Texas midwifery practice statutes indicates no such information as it relates to a definable re-entry program. The director also indicated that some states only require retaking the NARM examination as being part or all of the remediation for keeping or being reissued their license or certification.

NARM's published information contained in their Candidate Information Bulletin (CIB) provides information concerning "Suspension or Revocation of Application", "Revocation of Certification", and "Recertification". None of these processes could leave one to assume that a re-entry program that embraces a certain level of scrutiny beyond a written examination is offered to the midwife. Further, the director indicated that NARM has revoked only three certifications, all of whom were not licensed midwives practicing in California. None of the revoked certifications have been from a state with licensing statutes, nor have the former CPMs whose certifications/licenses had been previously revoked have reapplied for certifications or re-licensure. NARM publishes revocation notices in the CPM news, which is available on NARM's website. The director felt that it would not be of any direct benefit to inform the MBC of these revocation notices.

In order for eligible midwives to acquire the nationally recognized "certified professional midwives" (CPM) designation, they must be administered and successfully pass NARM's comprehensive certification examination. The national certification does not qualify the midwife for California licensure. However, the comprehensive examination is the Medical Board of California's licensing examination for midwives licensed in California, as required by statute.

Finally, the director validated that NARM's existing policies concerning certification does not meet the probable standard of a re-entry program and that it is not NARM's responsibility to monitor CPMs for compliance with state regulations. It is for this reason that NARM would not be involved unless a complaint was received by NARM. The effect of that notification would imperil the midwife to de-certification actions as a CPM.

UCSD Physician Assessment and Clinical Education (PACE) Program

Dr. Carole Sussman, Associate Director and COO, responded to a licensing staff e-mail and telephone inquiry concerning whether the existing PACE program for physicians could be tailored to the probable needs of licensed midwives. Dr. Sussman mentioned that the current PACE Program was designed expressly for healthcare professionals, with emphasis on physicians and surgeons. The PACE Program consists of a two-phased approach. Phase I of the program is a two-day clinical competency assessment that uses a variety of evaluative methods to provide an overall picture of the physician's skills, knowledge, and physical health. Phase II further evaluates the participant's skills and knowledge in a "clinical setting" by way of discussion with the faculty,

examination, and physician participation. The length of this portion of the evaluation is at least one week. Dr. Sussman further stated that it would be highly unlikely that the program could serve midwives in its current form and that a comparable program would have to be created for midwives. No further information or guidance relative to re-entry programs was provided. It was agreed that a PACE-like model could be used for midwives.

American College of Nurse-Midwives (ACNM)

Contact was made with several ACNM program directors regarding re-entry programs. It was disclosed that ACNM has created a "pilot program" titled "ACNM Reentry to Midwifery Practice Program". The purpose of the program appears to be designed "for midwives who are not currently engaged in the practice of midwifery and must update their skills and knowledge of current clinical practice after an extended absence to meet prevailing standards." The program consists of two components that include: 1) Continuing Education, and 2) Clinical Refresher.

The program guidelines identified certain information that concludes that re-entry or "refresher" programs were previously recognized during the late 1960s through the mid-1980s. During this period, foreign-prepared nurse-midwives were required to complete one of these refresher programs before being certified (not licensed) as a nurse-midwife in the United States. These refresher programs no longer exist, although the term "refresher" is used to describe the program designed for "reentering midwives" by one of the ACNM accredited education programs, which includes the following:

- OHSU Nurse-Midwifery Program, Portland, OR;
- San Diego State University, San Diego, CA;
- Baystate Medical Center. Springfield, MA;
- University of Medicine and Dentistry of New Jersey, Newark, NJ;
- University of Minnesota, School of Nursing, Minneapolis, MN; and the
- University of Puerto Rico, San Juan PR

The above listed ACNM accredited midwifery education programs have not been formally approved by the Medical Board of California. It could not be determined during this exchange whether the "pilot reentry programs" had been implemented at these locations. ACNM would not release information that disclosed the number of sites, if any, where the pilot program is being tested. Further, no additional program provisions considered or included conditions where the midwife had been referred to the program due to the imposition of disciplinary action that warrants competency assessments before re-licensing or re-certification.

Licensed Midwife Submission – Retraining Program for California Licensed Midwives:

During the conduct of this staff inquiry, contact was made with Faith Gibson, who presented a draft recommendation for a retraining program for midwives. This draft recommendation is the result of collaborations between Karen Ehrlich, and Elizabeth Gilmore, Director of the National College of Midwifery, Taos, New Mexico. Ms. Gibson, Ehrlich, and Gilmore are California licensed midwives. The latter is a Board-approved post secondary midwifery education program (school) currently in good standing with the Medical Board of California, Division of Licensing.

In summary, Ms. Gibson offers a process where midwives who have not practiced for extended periods of time would participate, on a voluntary basis, in the "360-degree prospective review process", similar in scope to that of the UCSD PACE model. Ms. Gibson's draft recommendation has been presented to Dr. Fantozzi in an earlier forum. Staff reviewed the three-paged document and found that the elements of the retraining process or design presented potential opportunities for a California retraining program for midwives. However, in its current form, revisions and structure may be required.

Discussion:

The information obtained during this inquiry did not validate the practicality or feasibility of implementing a re-entry or retraining program for midwives in California. At the core of this issue is the challenge of how the framework in which minimum standard competencies of the midwife will be assessed. Further, other issues facing the implementation of this type program that must be resolved include:

- **The design of the practical components of the program, e.g., competency assessment, peer review, retraining, and assessment outcomes, and other areas of concern;**
- **Whether or not the program would be voluntary upon request of the midwife, or mandatory, as a result of the imposition of disciplinary recommendations from the Division of Licensing;**
- **Probable revision of existing statutes and regulations to support program implementation, under the "force of law", which currently does not exist; and**
- **Program costs to the potential midwife involved and to the Medical Board of California to sustain this program over time. This issue may present circumstances that could be adverse to the forward movement of program implementation. The reason being that if high to nominal cost factors are not mitigated, midwives who may benefit from this program approach may not participate, due to the probability of high costs.**

Conclusions:

The examination of existing re-entry programs for midwives could not disclose any material or concrete information regarding any programs currently operating that could be considered a reentry program or model for midwives. NARM's existing programs or processes do not compare to what one would expect of a reentry program for an allied healthcare professional. The ACNM "Pilot Reentry Program" may be operating at several locations, but actual locations were not disclosed so that a preliminary assessment could be made of its feasibility. ACNM has not published any anticipated outcomes, performance measures, or expected results for the program. The existing PACE Program for healthcare professionals (physicians & surgeons) may not be suitable for midwives in its current configuration. However, using the framework of a PACE-like model may show some promise. The draft recommendation presented by Faith Gibson, with support from Karen Ehrlich and Elizabeth Gilmore, uses the UCSD PACE model, to a certain extent, but might require further revisions and improvements to be recognized as a potential example of a re-entry/retraining program for midwives.

Recommendations:

Due to the absence of any credible or concrete information concerning existing re-entry programs for midwives, this issue of concern could be exploited more fully and effectively by the soon-to-be-created Midwifery Advisory Council for the Division of Licensing. Once the members are impaneled, this subject could be thoroughly pursued by its members, using the resources of the existing midwifery community, in liaison and collaboration with other healthcare professionals. Partnerships could also be re-established with representatives of the California Medical Association (CMA), the American College of Obstetrics and Gynecologists (ACOG), represented midwifery advocacy groups and associations, in furtherance of any progress made to implement a program of this level of significance. Further, The Medical Board of California may be able to more effectively use the Expert Reviewer Program (Licensed Midwives) as an investigative and reporting arm of the Midwifery Advisory Council that would pursue probable alternatives of creating a Midwifery Assessment and Clinical Education Program, with supporting statutory authorities.

I look forward to answering any questions you might have at the meeting. If you have any questions or comments concerning this program proposal for midwives prior to the meeting, please contact me at (916) 263-2393 or by e-mail at hhill@mbc.ca.gov .

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR
MEDICAL BOARD OF CALIFORNIA – DIVISION OF LICENSING
1428 Howe Avenue, Suite 56, Sacramento, CA 95825-3204
Telephone (916) 263-2382 Fax (916) 263-2487 www.mbc.ca.gov

MEMORANDUM

DATE	August 10, 2007
TO	Members, Midwifery Advisory Council
FROM	Kathi Burns, Manager KB Licensing Operations Section
SUBJECT	**Schedule of Future Meetings**

The Division of Licensing has requested that the MAC meetings be held approximately one month prior to the Medical Board's quarterly meetings; therefore, the following schedule is proposed. All meetings will be held in Sacramento.

Upcoming Medical Board Meeting Dates	MAC Meeting Dates
January 31, February 1, 2008	December 9, 2007 (scheduled)
May 1, 2, 2008	April 3, 2008 (proposed)
July 24, 25, 2008	June 19, 2008 (proposed)
November 6,7, 2008	October 9, 2008 (proposed)

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR
MEDICAL BOARD OF CALIFORNIA – DIVISION OF LICENSING
1428 Howe Avenue, Suite 56, Sacramento, CA 95825-3204
Telephone (916) 263-2382 Fax (916) 263-2487 www.mbc.ca.gov

MEMORANDUM

DATE	August 10, 2007
TO	Members, Midwifery Advisory Council
FROM	Kathi Burns, Manager KB Licensing Operations Section
SUBJECT	**Future Matters for Consideration by the Council**

Below are possible future matters for consideration by the Council as discussed by the Division of Licensing.

1. Retraining/Re-entry to Practice Programs
2. Supervision of Licensed Midwives