BOARD OF REGISTERED NURSING
BILL ANALYSIS

BILL NUMBER: Senate Bill 667
AUTHOR: Senator Dodd
BILL DATE: February 16, 2023 – Introduced
SUBJECT: Healing arts: pregnancy and childbirth
SPONSOR: Certified Nursing Midwife Association (CNMA)

SUMMARY

The bill makes statutory changes to provisions impacting certified nurse midwives (CNM). The proposed changes are related to topics such as scope of practice, laboratory testing, hospital admitting privileges, and disability certifications, amongst others.

BACKGROUND

The Board of Registered Nursing (Board) is charged with certifying and regulating CNMs in California. A CNM is a registered nurse who attends cases of normal childbirth and provides prenatal, intrapartum, and postpartum care, including family planning care for mothers and immediate care for the newborn. In order to become a CNM, a RN typically completes a nurse-midwifery academic program of study which conforms with the Board's educational standards as set forth in 16 CCR Section 1462.

REASON FOR THE BILL

According to the author's office, California has made great strides to reduce maternal mortality and increase access to maternity and reproductive care in recent years. However, racial, economic, and geographic disparities in outcomes persist. For example, Black and Indigenous people remain 3 to 4 times more likely to die from pregnancy-related causes than their white counterparts. Additionally, California is in the midst of a maternity workforce crisis that has left at least 9 counties with no OB/GYNs at all and thus has left patients searching for care.

The author's office goes on to state that one piece of the solution is to allow these highly qualified providers to practice to the full extent of their scope as the original law establishing independent practice intended. The bill addresses redundancies and red tape revealed only through the everyday practice by midwives who experienced disruptive and unnecessary limitations to practice that SB 1237 (Dodd, 2020) intended to address.

ANALYSIS

1. CLIA Testing Exemption

Current law prohibits, except in certain circumstances, a person from performing a clinical laboratory test or examination classified as waived or classified as of moderate complexity under the federal Clinical Laboratory Improvement Amendments of 1988

(CLIA) unless the test or examination is performed under the overall operation and administration of the laboratory director.

This bill would expand the exempt circumstances by authorizing an alternative birth center or primary care clinic to perform testing and examinations classified as waived or a provider-performed microscopy consistent with services within the scope of the provider's license, if the following requirements are satisfied:

- If performing tests classified as waived, the alternative birth center or primary care clinic shall do both of the following:
    - The alternative birth center or primary care clinic obtains a valid CLIA certificate of waiver and complies with all other requirements for the performance of waived clinical laboratory tests under applicable federal regulations.
    - For purposes of CLIA, the person identified as responsible for directing and supervising testing oversight and decision making shall be a CNM licensed, a midwife licensed, or a physician and surgeon licensed pursuant to Chapter 5.

- If performing a provider-performed microscopy, the alternative birth center or primary care clinic shall do both of the following:
    - The alternative birth center or primary care clinic obtains a valid CLIA certificate for provider-performed microscopy.
    - For purposes of CLIA, the person identified as responsible for directing and supervising testing oversight and decision making shall be a CNM licensed or a physician and surgeon.

Two examples of a CLIA waived test are fern testing and wet mount.

According to CNMA, this would reduce costly barriers to birth center sustainability and start-ups by allowing CNMs to perform specific tests within their birth center or independent midwifery practice, consistent with federal CLIA laboratory rules.

2. Scope of Practice

Current law authorizes a CNM attend cases of low-risk pregnancy and childbirth and to provide prenatal, intrapartum, and postpartum care, including interconception care, family planning care, and immediate care for the newborn, consistent with the Core Competencies for Basic Midwifery Practice adopted by the American College of Nurse-Midwives, or its successor national professional organization, as approved by the Board.

A "low-risk pregnancy" is defined as a pregnancy in which all of the following conditions are met:

- There is a single fetus.

- There is a cephalic presentation at onset of labor.

- The gestational age of the fetus is greater than or equal to 37 weeks and zero days and less than or equal to 42 weeks and zero days at the time of delivery.

- Labor is spontaneous or induced.

- The patient has no preexisting disease or condition, whether arising out of the pregnancy or otherwise, that adversely affects the pregnancy and that the CNM is not qualified to independently address.

This bill would expand this section by authorizing a CNM to provide care for common gynecological conditions.

Currently CNMs can manage common gynecologic conditions, but only within certain discrete periods of time centered around pregnancy and conception. According to CNMA, this would reduce geographic and economic barriers to reproductive health care by improving the efficacy of the CNM workforce by extending the ability of CNMs to manage common gynecologic conditions across the lifespan.

3. Physician Involvement

Current law authorizes a CNM to practice with a physician and surgeon under mutually agreed-upon policies and protocols that delineate the parameters for consultation, collaboration, referral, and transfer of a patient's care, signed by both the CNM and a physician and surgeon to do either of the following:

- Provide a patient with care that falls outside the scope of services mentioned in the section above.

- Provide intrapartum care to a patient who has had a prior cesarean section or surgery that interrupts the myometrium.

This bill would remove reference to practicing, "with a physician and surgeon under mutually agreed upon policies and protocols" and instead authorize a CNM to provide the care specified in subparagraphs (A) and (B) pursuant to policies and protocols that are mutually agreed upon with a physician and surgeon.

Subparagraph A refers to care that falls outside of that scope of services specified in subdivision (a).

Subdivision (a) covers care that is consistent with the Core Competencies for Basic Midwifery Practice adopted by the American College of Nurse-Midwives (ACNM) and defines "low-risk pregnancy" within the Core Competencies for Basic Midwifery Practice that allows the scope of midwifery practice to be expanded beyond the Core Competencies to incorporate additional skills and procedures that improve care for the

individuals the midwives serve. This aligns with basic midwifery education and follows the guidelines outlined in Standard VIII of the Standards for the Practice of Midwifery which is included below.

Standard VIII
Midwifery practice may be expanded beyond the ACNM core competencies to incorporate new procedures that improve care for women and their families.

The midwife:

1. Identifies the need for a new procedure taking into consideration consumer demand, standards for safe practice, and availability of other qualified personnel.
2. Ensures that there are no institutional, state, or federal statutes, regulations, or bylaws that would constrain the midwife from incorporation of the procedure into practice.
3. Demonstrates knowledge and competency, including a) Knowledge of risks, benefits, and client selection criteria. b) Process for acquisition of required skills. c) Identification and management of complications. d) Process to evaluate outcomes and maintain competency.
4. Identifies a mechanism for obtaining medical consultation, collaboration, and referral related to this procedure.
5. Maintains documentation of the process used to achieve the necessary knowledge, skills and ongoing competency of the expanded or new procedures

Subparagraph B refers to providing intrapartum care to a patient who has had a prior cesarean section or surgery that interrupts the myometrium.

The ACNM have a position statement on Vaginal Birth After Cesarean Delivery that states, “CNMs and CMs are qualified to provide antepartum and intrapartum care for women who are candidates for a trial of labor after cesarean (TOLAC) including establishing appropriate arrangements for medical consultation and emergency care if necessary.”

It goes on to state that, “care of the woman who desires a TOLAC should include ongoing informed consent and risk assessment as well as heightened surveillance of fetal heart rate patterns according to established high-risk criteria in labor. Well-established and ongoing communication between midwifery and obstetric providers to facilitate transfer of care and surgical intervention if necessary is an essential component of promoting optimal outcomes for mothers and their newborns. Women who attempt a TOLAC are successful 60-80% of the time. Vaginal birth after cesarean reduces the likelihood of maternal morbidity associated with multiple cesarean deliveries.”

According to CNMA, this would advance integration and sustainability of independent midwifery care by clarifying that CNMs do not have to be “in the same practice with” a physician in order to consult and collaborate.

4. Admitting Privileges

Under current law, some hospitals bylaws already allow for CNMs with privileges to admit and discharge patients. However, there has been some debate as to whether a CNM must be under the supervision of a physician in order to complete the tasks associated with the admission and discharge of patients.

The bill would clarify that a CNM who holds privileges in a general acute care hospital can admit and discharge patients upon their own authority if in accordance with the bylaws of that facility and within the CNM's scope of practice. This will not require hospitals to provide CNM with independent admitting privileges, but rather it will clarify they are legally able to if they so choose.

According to CNMA, this would improve midwifery integration and collaboration within and between different sites of care, by allowing admission and discharge capability for nurse-midwives with hospital privileges, consistent with CNM scope of practice.

5. Furnishing Authority

Current law authorizes a CNM to furnish drugs or devices incidentally to the provision of care and services that the CNM is authorized to perform, and care rendered to persons within certain settings, subject to specified requirements and exceptions. One of those requirements is for a CNM to follow standardized procedures or protocols if they furnish, or order, Schedule IV or V controlled substances or drugs or devices for services other than attending cases of low-risk pregnancy and childbirth or providing prenatal, intrapartum, and postpartum care. The standardized procedures or protocols must specify which CNM is authorized to furnish or order drugs or devices, which drugs or devices may be furnished or ordered and under what circumstances, and the method of periodic review of the CNM's competence and review of the provisions of the standardized procedure.

In addition, current law also requires a CNM to follow a patient-specific protocol approved by a physician and surgeon if the CNM furnishes or orders Schedule II or III controlled substances for any condition. The patient-specific protocol must address the diagnosis of the illness, injury, or condition for which a Schedule II controlled substance is to be furnished.

Lastly, current law authorizes a CNM to procure supplies and devices, obtain and administer diagnostic tests, obtain and administer nonscheduled drugs consistent with the provision of services authorized to be performed without policies and protocols mutually agreed upon with a physician and surgeon, order laboratory and diagnostic testing, and receive reports.

This bill would make the following changes related to CNM furnishing authority:

1. Remove references to standardized procedures or protocols. Instead, the bill would require the policies and protocols that a CNM is required to follow for certain care to contain provisions governing the furnishing or ordering drugs or devices for services other than attending cases of low-risk pregnancy and childbirth or providing prenatal, intrapartum, and postpartum care, as specified.

2. Require those policies and protocols to contain a patient-specific protocol that identifies the patient conditions for which a CNM is authorized to furnish or order a Schedule II or III controlled substance.

3. Authorize a CNM to dispense drugs that are not dangerous when attending cases of low-risk pregnancy and childbirth or providing prenatal care, intrapartum care, postpartum care, or care for common gynecologic conditions.

According to CNMA this would remove costly, unnecessary barriers to practice by allowing controlled substances for conditions within the CNM low-risk scope to be furnished without the administrative barrier of a standardized procedure in the same way that other medications within the CNM low-risk scope do not require a standardized procedure. It would also strengthen CNMs role as abortion providers and providers for disadvantaged populations by clarifying the ability of CNM to dispense medication directly to patients.

BRN staff met with CNMA and shared that some amendments would be needed to specify that the granting of a furnishing license must be in alignment with the education and scope of practice of the CNM. CNMA was agreeable to this recommendation.

6. Disability Benefits

Current law states that a claimant must establish medical eligibility for each uninterrupted period of disability by filing a first claim for disability benefits supported by the certificate of a treating physician or practitioner that establishes the sickness, injury, or pregnancy of the employee, or the condition of the family member that warrants the care of the employee.

A “practitioner” is defined as a person duly licensed or certified in California acting within the scope of his or her license or certification who is a dentist, podiatrist, or a nurse practitioner, and in the case of a nurse practitioner, after performance of a physical examination by a nurse practitioner and collaboration with a physician and surgeon, or as to normal pregnancy or childbirth, a midwife or nurse midwife, or nurse practitioner.

This bill would amend the definition of practitioner to replace the phrase “normal pregnancy or childbirth” with the phrase “low-risk pregnancy and childbirth or postpartum conditions consistent with the scope of their professional licensure.”

According to CNMA, this would reduce health care costs, unnecessary appointments, and administrative barriers to person-centered care by allowing for temporary disability

certification by CNMs for the entirety of someone's pregnancy, consistent with midwifery scope of practice.

FISCAL IMPACT
Staff is still researching the potential fiscal impact of this bill.

SUPPORT
- Certified Nursing Midwife Association

OPPOSITION
- None on File.

LEGISLATIVE COMMITTEE POSITION
Not Applicable.

FULL BOARD POSITION
To Be Determined.