



## **Frequently Asked Questions (FAQs) related to midwifery practice and the implementation of Senate Bill (SB) 1237 (Reg. Sess. 2019-2020)**

On September 18, 2020, Governor Newsom signed SB 1237 into law which broadened the certified nurse midwife (CNM) scope of practice and made other changes to the Nursing Practice Act. The changes to allow additional independence for CNMs in California commenced on January 1, 2021. Below are FAQs related to the implementation of SB 1237.

### ***What is the CNM's Independent Scope of Practice in California?***

CNMs may provide care, in the hospital or any out-of-hospital setting, for low-risk pregnancy and childbirth, prenatal, intrapartum and postpartum care, 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 (ACNM) or its successor organization. ([Bus. & Prof. Code, § 2746.5, subd. \(a\)](#))

Low-risk pregnancy is defined as:

- (1) There is a single fetus.
- (2) There is cephalic presentation at the onset of labor.
- (3) The gestational age of the fetus is greater than or equal to 37 weeks and zero (0) days and less than or equal to 42 weeks and zero (0) days at the time of delivery.
- (4) Labor is spontaneous or induced.
- (5) 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 per the [Core Competencies for Basic Midwifery Practice](#) adopted by ACNM or its successor organization.

### ***Can CNMs care for patients who fall outside of the defined low-risk scope?***

Yes. CNMs may provide care for patients who fall outside of the independent scope of services delineated in subdivision (a) of Business and Professions Code section [2746.5](#), and may provide intrapartum care to a patient with a previous cesarean section or a surgery involving the myometrium, with signed mutually agreed-upon policies and protocols with a physician that delineate the parameters for consultation, collaboration, referral, and transfer of care. ([Bus. & Prof. Code, § 2746.5, subd. \(b\)](#))

### ***Must CNMs be supervised by a physician in order to provide care for patients who fall outside of the defined low-risk scope?***

No. In providing care under mutually agreed-upon policies and protocols to patients who fall outside of the independent scope of services delineated in subdivision (a), subdivision (b) of Business and Professions Code section [2746.5](#) does not require direct or indirect physician supervision of the CNM, nor does it require the CNM and physician to have a Collaborative Practice Agreement in place. Additionally, subdivision (b) of Business and Professions Code section [2746.5](#) does not necessarily



require that the CNM consult, collaborate, refer, or transfer care to the specific physician who signs the mutually agreed-upon policies and protocols. ([Bus. & Prof. Code, § 2746.5, subd. \(b\)](#))

***Is a CNM required to always have mutually agreed-upon, signed policies and protocols with a physician in order to practice?***

No. If the CNM is providing care and services within the independent scope of services described in subdivision (a) of section [2746.5](#) of the Business and Professions Code, the CNM is not required to have any mutually agreed-upon, signed policies and protocols with a physician in order to practice.

Subdivision (a) also points to the [Core Competencies for Basic Midwifery Practice](#) by ANCM as a foundational guide for determining what the CNM is qualified to independently address within prenatal, postpartum, and intrapartum care, family planning and interconception care, and immediate care of the newborn. ([Bus. & Prof. Code, § 2746.5, subd. \(k\)](#))

***What if a CNM does not have these “mutually agreed-upon policies and protocols” signed by a physician?***

If a CNM does not have mutually agreed-upon policies and protocols with a physician in order to provide care for patients who fall outside of the independent scope of services delineated in subdivision (a) of Business and Professions Code section [2746.5](#), the CNM will transfer any such patient to the care of a physician and surgeon, including to provide intrapartum care to a patient who has had a prior cesarean section or prior surgery that interrupts the myometrium ([Bus. & Prof. Code, § 2746.5, subd. \(c\)](#)). Note, for patients that have had a previous cesarean or require surgery that interrupts the myometrium, this subdivision does not prohibit the CNM from providing prenatal care – the statute only requires the CNM to transfer such patients’ care to a physician during the intrapartum period.

***What if the CNM is attending the labor of a patient who intends to give birth in an out-of-hospital setting, and who started labor at a gestational age less than 42 weeks, but who is now at exactly 42 weeks gestation and otherwise “low-risk”?***

For patients intending to give birth in an out-of-hospital setting, and who are no longer considered low-risk because the gestational age of the fetus is more than 42 weeks and zero (0) days, a CNM without mutually agreed-upon policies and protocols with a physician must initiate transfer to physician care for such patients. However, if such a patient otherwise meets all of the other criteria for “low-risk” as defined in subdivision (a) of section [2746.5](#) of the Business and Professions Code, and it is determined that there is insufficient time to safely transfer the patient to a hospital prior to delivery, or if transfer in that moment poses a threat to the health and safety of the patient or unborn child, the CNM may continue to provide care in the out-of-hospital setting, consistent with their transfer plan ([Bus. & Prof. Code, § 2746.5, subd. \(c\)\(2\)](#)). The transfer plan must be in accordance with the requirements of Business and Professions Code section [2746.54](#), subdivision (a), and must be disclosed to a prospective patient in oral and written form, with informed consent obtained.



***If a patient is transferred to physician care, can they ever return to the care of the CNM?***

Yes. Any patient who has been transferred to physician care may return to the care of the CNM after the physician has determined that the condition or circumstance that required transfer, or would require transfer, is resolved. ([Bus. & Prof. Code, § 2746.5, subd. \(c\)\(3\)](#))

***Can a CNM in California perform a vacuum or forceps extraction, or perform an external cephalic version?***

No. ([Bus. & Prof. Code, § 2746.5, subd. \(f\)](#))

***Does the law require anything specific in terms of documentation of patient care?***

Yes. The law requires CNMs to document all consultations, referrals, and transfers in the patient record. ([Bus. & Prof. Code, § 2746.5, subd. \(g\)](#))

***What is required of the CNM in emergency situations?***

A CNM must refer all emergencies to a physician and surgeon immediately and may provide emergency care until the assistance of a physician is obtained. ([Bus. & Prof. Code, § 2746.5, subd. \(h\)](#))

***Are CNMs required to have physician supervision for furnishing medications?***

No, SB 1237 removed the 4:1 physician supervision ratio for furnishing of medication. CNMs may furnish drugs or devices incidental to their scope of practice. In some cases, standardized procedures or patient-specific protocols are required for furnishing of drugs or devices. ([Bus. & Prof. Code, § 2746.51](#))

***When is a CNM required to have standardized procedures for furnishing drugs or devices?***

Standardized procedures are required for furnishing drugs or devices:

- (1) When furnishing or ordering drugs or devices for services that do not fall within the independent scope of services specified in subdivision (a) of section [2746.5](#) of the Business and Professions Code.
- (2) When furnishing or ordering Schedule IV or V controlled substances at any time, even if ordering these medications incidental to the independent scope of services described in subdivision (a) of section [2746.5](#) of the Business and Professions Code. ([Bus. & Prof. Code, § 2746.51, subd. \(a\)\(2\)](#))



### ***What are the required components of a standardized procedure for furnishing drugs or devices by a CNM?***

Subdivision (a)(2) of section [2746.51](#) of the Business and Professions Code requires that standardized procedures, for the specific purposes of furnishing drugs or devices by a CNM, must be developed in collaboration with and approved by a physician and the CNM. The standardized procedure covering the furnishing or ordering of drugs or devices must include the following:

- (1) Which CNM may furnish or order drugs or devices.
- (2) Which drugs or devices may be furnished or ordered and under what circumstances.
- (3) The method of periodic review of the CNM's competence, including peer review, and review of the provisions of the standardized procedure.

[\(Bus. & Prof. Code, § 2746.51, subd. \(a\)\(2\)\)](#)

Of note, if utilizing a standardized procedure for anything other than furnishing drugs or devices by a CNM, California Code of Regulations, title 16, section [1474](#) (which was jointly promulgated by the Medical Board of California and by the California Board of Registered Nursing (BRN)), identifies requirements pertaining to general standardized procedures.

### ***When is a patient-specific protocol necessary for the furnishing of medication?***

If Schedule II or III controlled substances are furnished or ordered by a CNM for any condition, even for services that fall within the independent scope of services specified in subdivision (a) of Business and Professions Code section [2746.5](#), the controlled substances must be furnished or ordered in accordance with a patient-specific protocol approved by a physician. For Schedule II controlled substance protocols, the provision for furnishing the Schedule II controlled substance must be specific – beyond simply a category of illness for which the medication can be furnished – and must address the actual diagnosis of the illness, injury, or condition for which the Schedule II controlled substance is to be furnished. [\(Bus. & Prof. Code, § 2746.51, subd. \(a\)\(3\)\)](#)

### ***Are there specific requirements for CNMs who furnish drugs or devices?***

Yes.

- (1) The CNM must have a furnishing number issued by the BRN. This number must be included on all transmittals of orders for drugs or devices by the CNM.
- (2) The CNM must complete a course in pharmacology covering the drugs or devices to be furnished, and the course must include the risks of addiction and neonatal abstinence syndrome associated with the use of opioids.
- (3) Upon request by a licensed pharmacist who is uncertain of the authority of the CNM to furnish or order drugs or devices, a CNM must provide the pharmacist with a copy of the standardized procedure or protocol relating to the furnishing or ordering of controlled substances by the CNM.



- (4) For furnishing controlled substances, the CNM must register with the United States Drug Enforcement Administration (DEA) and the Controlled Substance Utilization Review and Enforcement System (CURES) pursuant to Section [11165.1](#) of the Health and Safety Code. The CNM must provide documentation of board approved continuing education specific to the use of Schedule II controlled substances in settings other than a hospital. ([Bus. & Prof. Code, § 2746.51, subd. \(b\)](#))

***Can I directly procure drugs and devices that are critical to my practice setting, administer or order laboratory tests, or request patient reports?***

Yes. Subdivision (f) of section [2746.51](#) of the Business and Professions code supersedes any potential conflicting provisions of law and allows CNMs to directly procure supplies and devices, obtain and administer diagnostic tests, and directly obtain and administer nonscheduled drugs consistent with the provision of services that fall within the scope of services specified in subdivision (a) of section [2746.5](#) of the Business and Professions Code, order laboratory and diagnostic testing, and receive reports that are necessary to their practice as a CNM consistent with section [2746.5](#) of the Business and Professions code. ([Bus. & Prof. Code, § 2746.51, subd. \(f\)](#))

***Do CNMs still need a Standardized Procedure to repair lacerations or to perform an episiotomy?***

No. CNMs may repair first- and second-degree lacerations of the perineum, and perform episiotomies in any birth setting, including the home, without standardized procedures. CNMs must ensure that all complications are referred to a physician and surgeon immediately. Additionally, the CNM must ensure the immediate care of patients who are in need of care beyond the CNM's scope of practice and ensure timely emergency care can be obtained in situations when a physician is not on the premises. ([Bus. & Prof. Code, § 2746.52](#))

***When are disclosures and informed consent for CNM care necessary?***

Disclosures and informed consent for CNM care are only required when the patient's intended site of birth is an out-of-hospital setting, such as a birth center or the home. These disclosures must be provided to a prospective patient as part of a patient care plan, and informed consent must be obtained from the patient. ([Bus. & Prof. Code, § 2746.54](#))

***What is the required format of the disclosures and what must be included?***

When disclosures are required for the provision of CNM care due to the intended birth site being in an out-of-hospital setting, a CNM must disclose in both oral and written form to a prospective patient as part of a patient care plan, and obtain informed consent for, all of the following:

- (1) The patient is retaining a CNM and the CNM is not supervised by a physician and surgeon.
- (2) The CNM's current licensure status and license number.
- (3) The practice settings in which the CNM practices.



- (4) If the CNM does not have liability coverage for the practice of midwifery, the CNM shall disclose that fact.
- (5) There are conditions that are outside of the scope of practice of a CNM that will result in a referral for a consultation from, or transfer of care to, a physician and surgeon.
- (6) The specific arrangements for the referral of complications to a physician and surgeon for consultation. The CNM shall not be required to identify a specific physician and surgeon.
- (7) The specific arrangements for the transfer of care during the prenatal period, hospital transfer during the intrapartum and postpartum periods, and access to appropriate emergency medical services for mother and baby if necessary, and recommendations for pre-registration at a hospital that has obstetric emergency services and is most likely to receive the transfer.
- (8) If, during the course of care, the patient is informed that the patient has or may have a condition indicating the need for a mandatory transfer, the CNM shall initiate the transfer.
- (9) The availability of the text of laws regulating midwifery practices and the procedure for reporting complaints to the BRN, which may be found on the BRN's internet website.
- (10) Consultation with a physician and surgeon does not alone create a physician-patient relationship or any other relationship with the physician and surgeon. The CNM shall inform the patient that CNM is independently licensed and practicing midwifery and in that regard is solely responsible for the services the CNM provides.

The disclosure and the patient's informed consent shall be signed by both the CNM and the patient and a copy of the disclosure and consent shall be placed in the patient's medical record. ([Bus. & Prof. Code, § 2746.54](#))