Nurse-Midwifery Advisory Committee Meeting

MEETING MATERIALS

March 18, 2025

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Agenda Item 2.0

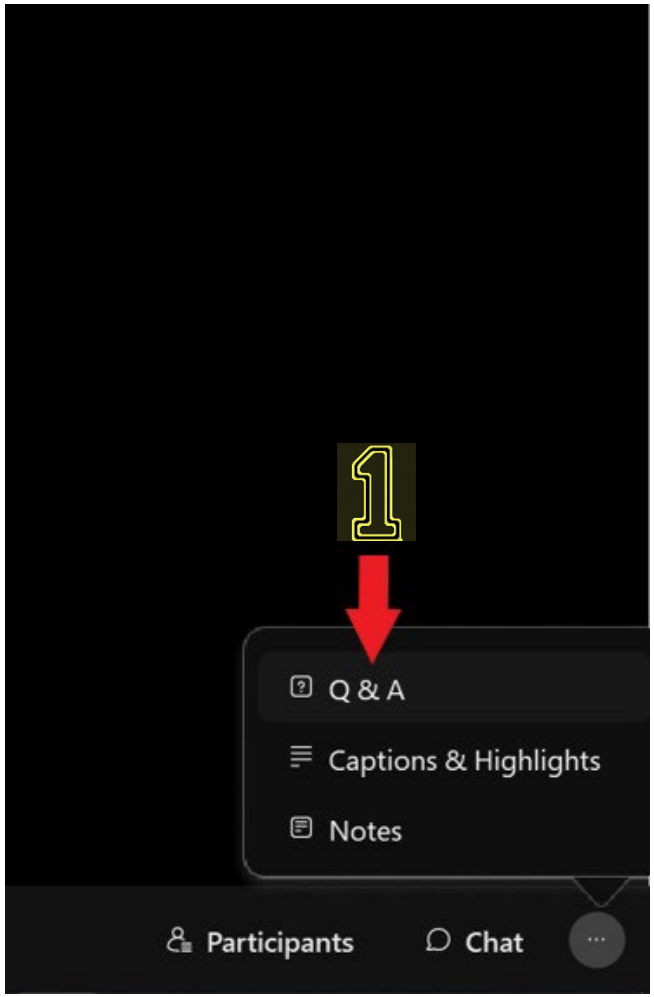
General instructions for the format of a teleconference meeting

Nurse-Midwifery Advisory Committee (NMAC) Meeting | March 18, 2025

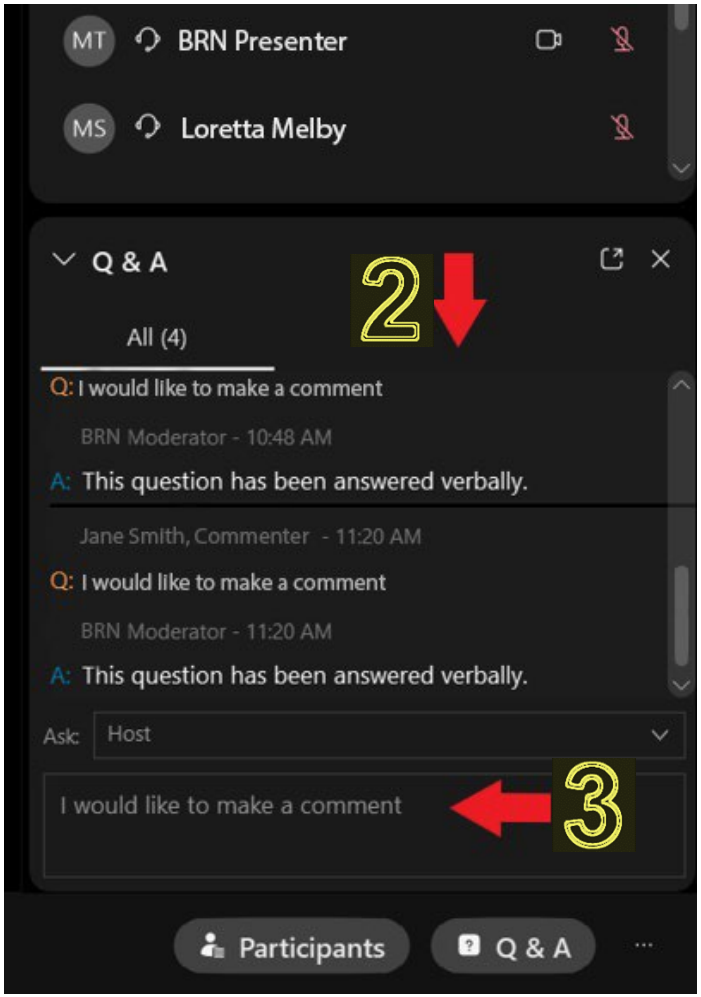
Participating During a Public Comment Period *(if joining the meeting remotely via WebEx)*

If you would like to make a public comment:

1. Click on the 'Q & A' button at the lower right of your WebEx session (you may need to click the three dots (…) to find this option).



2. The 'Q & A' panel will appear.



3. In the 'Q & A' panel, type "I would like to make a comment". You will be identified by the name or moniker you used to join the WebEx session, your line will be opened (**click the 'Unmute me' button**), and you will have **two (2) minutes** to provide comment. Every effort is made to take comments in the order which they are requested.

NOTE: Please submit a new request for each agenda item on which you would like to comment.

Agenda Item 4.0

Review and vote on whether to approve previous meeting's minutes.

Nurse-Midwifery Advisory Committee (NMAC) Meeting | March 18, 2025

DRAFT

BOARD OF REGISTERED NURSING
NURSE-MIDWIFERY ADVISORY COMMITTEE
COMMITTEE MEETING MINUTES

DATE: September 24, 2024

START TIME: 9:02 am

LOCATION: The Board of Registered Nursing's Nurse Practitioner Advisory Committee (NPAC) held a public meeting in accordance with Government Code section 11123.5 that was accessible via a teleconference platform and at the primary physical meeting location indicated below:

1625 North Market Blvd.,
El Dorado Room N-220
Sacramento, CA 95834

9:03 am **1.0** **Call to Order/Roll Call/Establishment of a Quorum**
Jenna Shaw-Battista – Chair, called the meeting to order at 9:03 am. Quorum established at 9:04 am.

Nurse-Midwifery Advisory Committee Members:
Jenna Shaw-Battista, PhD, RN, PHN, NP, CNM, FACNM – Chair
Ruth Mielke, PhD, CNM, FACNM, WHNP-BC
Lilit Sarkissian, CNM, MSN, RNC-OB
James Byrne, MD - Absent
Kenneth James, MD
Rebecca DeSantis - Absent

BRN Staff Representatives:
Loretta Melby, RN, MSN, Executive Officer
Harry Skaletzky, DCA Legal Affairs Division, Attorney

9:07 pm **3.0** **Public comment for items not on the agenda; items for future agendas.**

Public Comment for Agenda Item 3.0:
Holly Smith – Would like to ensure regulations be promulgated for SB 667 since it was signed one year ago.

Loretta Melby said this is on the agenda and invited further comment when that item is discussed.

9:09 am **4.0** **Review and vote on whether to approve previous meetings minutes**

4.1 March 26, 2024

Discussion: No comments or questions.

Motion: **Lilit Sarkisian:** Motioned to approve minutes.

Second: **Jenna Shaw-Battista**

9:13 am **Public Comment for Agenda Item 4.0:** No public comments in any location.

Vote:

Vote	JSB	RM	LS	JB	KJ	RD	
	Y	Y	Y	AB	Y	AB	
Key: Yes: Y | No: N | Abstain: A | Absent for Vote: AB							

Motion Passed

9:11 am **5.0** **Discussion and possible action: Regarding meeting dates for 2025.**

Discussion: Jenna Shaw-Battista said these look like the dates for previous meetings and she says they look good.

Lilit Sarkisian said she likes the dates as well.

Motion: **Jenna Shaw-Battista:** Motioned to approve

Second: **Ruth Mielke**

9:13 am **Public Comment for Agenda Item 5.0:** No public comments in any location.

Vote:

Vote	JSB	RM	LS	JB	KJ	RD	
	Y	Y	Y	AB	Y	AB	
Key: Yes: Y | No: N | Abstain: A | Absent for Vote: AB							

Motion Passed

9:18 am **6.0** **Information only: Data on final dispositions of disciplinary cases against Certified Nurse Midwives (CNM).**

Discussion: Ruth Mielke asked for clarification on 801 practice. Shannon Johnson said any insurance claim over $10,000 must be reported to the board and the board will conduct an investigation if needed. Ruth Mielke asked if the types of discipline and violation types are for the same person since the numbers are identical. Shannon Johnson said there's no duplicative information. Each year represents the actual year that the disciplinary action has been concluded. The disposition is in the year where it's reported. Each year stands on its own and they are individual disciplinary actions for each. Loretta Melby added more information for context. Shannon Johnson explained the voluntary surrender during probation in 2018.

Jenna Shaw-Battista asked for examples of what would fall into the other violation types since there seem to be some in most years. Shannon Johnson could not recall and said she would have to pull the data so she doesn't misspeak on it. Jenna Shaw-Battista said these are really small numbers so it wouldn't make sense to ask about trends but she is curious of any kind of comparison to other licensee types or similarities between discipline cases among midwives. Shannon Johnson said the nurse-midwifery population is very small but is very comparable to every other advanced practice certification. Even as to the RNs, who number over half a million, the numbers run along the lines with RN disciplinary actions with less than 1% of the population. Loretta Melby asked about the 801s being more on the certificate holders and less on RNs. Shannon Johnson agreed. Jenna Shaw-Battista said practice is a clinical issue

Public Comment for Agenda Item 6.0:

Holly Smith – Asked about 801 practice and whether it could be more than one type. She asked if convictions include any criminal convictions. Loretta Melby said convictions are any criminal conviction and the 801-practice number is not the same as the other practice cases listed in the materials.

"NP Still Watching" – She referred to the data in the NP committee and said it might be helpful to see all advance practice data. She said the numbers are higher and there has been one license reinstated which is very low even if the conviction happened in 2017 and may not have been a DUI. Anyone can be disciplined and she asked for the committee to look at the big picture. Loretta Melby added context to say Public Reproval and Probation does not cause loss of license and does not require reinstatement since the license remains active and licensee is able to remain in practice. The Surrender, Voluntary Surrender and Revocations are the only three lines that cover where a license is no longer able to be utilized which would potentially require a reinstatement if they were to return to practice. The reason why they did not include the NP data here is that it is mandated in law to go to the NPAC just like the midwives are mandated for this data to be presented to NMAC. Whether the data is for NMAC or NPAC that does not include all advance practice RNs. There are two other advance practice groups, the CRNAs and CNSs, who do not have meetings today and their data has not been pulled. She explained where the data could be found and is reported out to the board. Shannon Johnson said reinstatements require a nurse to request the license back in the reinstatement process. Loretta Melby said the BRN doesn't necessarily deny the reinstatement but the person who was revoked or surrendered chose not to ask for their license back.

9:37 am **7.0** **Discussion and possible action: Regarding discussion of the following subcommittees: Public Engagement and Website; Nurse Midwifery Scope of Practice; Regulations; and Nurse Midwifery Education.**

	Discussion:	Nurse Midwifery Scope of Practice: Jenna Shaw-Battista and Ruth Mielke said they haven't had any communications or inquiries and not tackled any new topics. They have not met. Regulations: Lilit Sarkisian said she and James Byrne have not met Nurse Midwifery Education: Kenneth James said they have not met and said he will be more attentive for the next meeting. Loretta Melby offered to have a kickoff meeting with the subcommittees to talk about different items of focus and to answer any questions the members may have and try to help facilitate working on their own in between meetings. She gave an example of the next agenda item. She said the work begins in the subcommittees.
	Motion:	No motion made.
	Public Comment for Agenda Item 7.0:	No public comments in any location.
9:45 am	**8.0**	**Discussion and possible action: California Nurse-Midwives Association (CNMA) requests to update the BRN website regarding the passage of SB 667 (Reg. Sess. 2022-2023).**
	Discussion:	Jenna Shaw-Battista said there are some outdated links from 2012 and 2013 documents on the website. This needs links updated from the midwifery page to the NPA, website for authorization for RNs to dispense drugs and devices, scope, FAQs that the committee worked on in 2022 that needs some wordsmithing by the subcommittee. Loretta Melby showed the BRN website. She spoke about the Nurse-Midwife page and the links mentioned. She clicked on a link for SB 667 and spoke about which laws were updated and where they could be found. She said some of the laws are not in the NPA and refer to other department's websites. She brought up the NPA webpage listing the statutes and regulations. She clicked on the various laws and regulations. She spoke about the regulations pertaining to nurse midwives. She explained the difference between statute and regulation. Jenna Shaw-Battista said the agenda item was to clean up the CNM website and make it user friendly. She said when outside parties go to the BRN website and search for certain information they aren't able to find the information Loretta Melby is speaking about because they may not be savvy to the location of information on the BRN website. She said this could be tabled and she would work with Loretta Melby to go through the website like an outside consumer. Loretta Melby pointed out where to find Nursing Practice Act (NPA) information again. She showed the Nurse-Midwife page under Practice tab on the opening page. She showed the FAQs. Jenna Shaw-Battista said that is the only

document that needs to be updated and there are some broken links in need of fixes. She said the broken links are in the email. Loretta Melby said she has the original email that references various information and that is why she showed where to find the NPA. She understands there is some overlap between NP and CNM and can work on that. She said licensing information can be updated as well. She spoke about dispensing versus furnishing and can look at whether there is something specific that needs to be updated. Loretta Melby asked Holly Smith to be elevated to speak from the California Nurse Midwife Association (CNMA). Jenna Shaw-Battista said the document about nurse-midwives being outdated from 2012. Loretta Melby said the document referencing BPC 2725.1 and that law has not been updated since 2012 and that is why this hasn't been changed. She spoke about the difference between dispensing and furnishing.

Holly Smith asked if information can be added to the FAQ so EDD can see the information. Loretta Melby said it could and shared her screen to show where links are on the BRN website. A link could be added for insurance. She also said a separate FAQ could be developed for midwifery practice subsequent to SB 667, or could be added to the existing FAQ based on feedback and which would be more beneficial. Holly Smith asked if feedback should be directed to the subcommittee. Loretta Melby said yes and that she believes SB 667 does not require additional regulations. The FAQ can say CNM care for patients so everyone in the public has it as well. CNM care for patients that falls outside the defined low risk scope can reference back to the statutory language in 2746.5(b). They will look to make FAQs as usable as possible and reference back to the specific codes because that's where EDD, CMS, CDPH will look, because that's where the scope of practice comes from. Holly Smith said the only thing she can see that needs a regulatory change is "care for common gynecologic conditions outside of pregnancy" because that is different than what is in the regulations right now for scope which only includes "within pregnancy conditions and interconception care." She thinks "care for common gynecologic conditions across the lifespan" is such a specific practice that it should be clarified that it is in fact the case now for nurse midwives outside of even the pregnancy state. She said this is new and could be updated or changed. This could be an easy fix. Loretta Melby agreed so this could align with the statutory language. She said this would still have to go through the regulatory change process which could take a couple of years. She said the language would come back to this advisory committee. She said if the change is non-substantive, it might be brought in a section 100 change.

Ruth Mielke asked if CNMA can be consulted and add another set of eyes for review. Loretta Melby said anyone outside of NMAC members can be consulted with. Ruth Mielke asked if they need to let BRN know who they meet with. Loretta Melby said no it is not necessary. It could be reported out at a meeting like agenda item 6.0.

Jenna Shaw-Battista said this sounds like this is an information only and can open up to public comment.

Motion: No motion made.

10:20 am **Public Comment for Agenda Item 8.0:** Holly Smith – said this has been very helpful.

10:21 am **9.0** **Discussion and possible action: Regarding input from NMAC on changes to the BRN Disciplinary Guidelines, to provide recommendations or guidance on care when the Board is considering disciplinary action against a CNM.**

Discussion: Ruth Mielke asked if there is a prescribed format for deciding the plan of supervision. Who does it, how often do they meet. Loretta Melby explained the current enforcement NEC process for review of employment and worksite monitors for supervision. Shannon Johnson gave more information regarding the NEC review for a workplace supervisor and what might be required of the probationer and/or supervisor. Ruth Mielke asked if the nurse has access to a consultant who may provide supervision for the APRN on probation. When you're talking about a 12-hour shift worksite monitor that may not fit if you're on call for 24 hours. Loretta Melby said that would be correct and the language for shift work would not be used for APRNs as it is for RNs. The new language in (e) is for the APRN in an independent setting that does not use standardized procedures. The CNM provides the information for the supervisor and a plan is developed for the supervision. She pointed the members to section (e) as the only one that applies to APRNs. All other sections apply to RNs.

Jenna Shaw-Battista said it is an independent practitioner and not the setting. She gave an example of a CNM working in a hospital without a supervisor in a low-risk scope. How would the CNM find a supervisor without a business or personal relationship? She asked where the timelines come from and whether they are realistic if the CNM had to get somebody credentialed in the hospital to supervise them. Loretta Melby said the CNM could look at the hospital setting to see the chief of staff or chief of medical staff who does not have a direct business relationship with them because they're not signing your check or paying for you. The person doesn't have to have private practice and the CNM could look to see if there is somebody there that would allow for supervisions while the CNM is there. There can be multiple supervisors to fill in when the CNM is working. It could be another CNM not in their own practice setting and at the hospital who can work collaboratively with the CNM as the supervisor. All that would be presented for consideration. Jenna Shaw-Battista asked if there were multiple supervisors versus one and how would that work with access to multiple sites or locations and patient records. Loretta Melby said that for the CNM to work there has to be an approved plan. She discussed the patient record

that is created with a CNM in their practice and the availability of a supervisor to review the chart. Loretta Melby asked if either of the MDs could share this with the Medical Board. Kenneth James said he never experienced this but did supervise multiple midwives. He said it would be tough. He said if this happens it would be difficult and there could be a loss of income and favors will need to be asked so hopefully you have built good relationships with people at the hospital who are willing to cover for you. He said most hospitals have a laborious program with laborists who would be happy to supervise work in the hospital. Practice may need to be changed from five days to one to get supervision.

Motion: **Kenneth James:** Motioned to approve the updated language on Probation Conditions #8 Supervision.

Second: **Lilit Sarkisian**

10:49 am **Public Comment for Agenda Item 9.0:** No public comment in any location.

Vote:

Vote	JSB	RM	LS	JB	KJ	RD	
	A	Y	Y	AB	Y	AB	
Key: Yes: Y | No: N | Abstain: A | Absent for Vote: AB							

Motion Passed

10:52 pm **10.0** **Adjournment: Jenna Shaw-Battista**- Chair, adjourned the meeting at 10:52 a.m.

Submitted by:

McCaulie Feusahrens
Chief of Licensing
Licensing Division
California Board of Registered Nursing

Accepted by:

Mary Kay Phillips, PhD, CNM
Chair
Nurse-Midwifery Advisory Committee

Loretta Melby, MSN, RN
Executive Officer
California Board of Registered Nursing

Agenda Item 5.0

Discussion and Possible Action: Regarding discussion of the following subcommittees: Public Engagement and Website, Nurse Midwifery Scope of Practice, Regulations, and Nurse Midwifery Education

Nurse-Midwifery Advisory Committee (NMAC) Meeting | March 18, 2025

BOARD OF REGISTERED NURSING
Nurse-Midwifery Advisory Committee Meeting
Agenda Item Summary

AGENDA ITEM: 5.0
DATE: March 18, 2025

ACTION REQUESTED: **Discussion and Possible Action:** Regarding discussion of the following subcommittees: Public Engagement and Website, Nurse-Midwifery Scope of Practice, Regulations, and Nurse-Midwifery Education

REQUESTED BY: Jenna Shaw-Battista, PhD, RN, PHN, NP, CNM, FACNM
Chair

BACKGROUND:

The following four NMAC subcommittees will provide updates on their topics, any work conducted, etc.:

- Public Engagement and Website
- Nurse-Midwifery Scope of Practice
- Regulations
- Nurse-Midwifery Education

RESOURCES:

NEXT STEPS:

FISCAL IMPACT, IF ANY: None

PERSON(S) TO CONTACT:
McCaulie Feusahrens
Chief of the Licensing Division
California Board of Registered Nursing
mccaulie.feusahrens@dca.ca.gov

Agenda Item 6.0

Information only: Data on final dispositions of disciplinary cases against Certified Nurse-Midwives

Nurse-Midwifery Advisory Committee (NMAC) Meeting | March 18, 2025

BOARD OF REGISTERED NURSING
Nurse-Midwifery Advisory Committee Meeting
Agenda Item Summary

AGENDA ITEM: 6.0
DATE: March 18, 2025

ACTION REQUESTED: **Information only:** Data on final dispositions of disciplinary cases against Certified Nurse-Midwives (CNM)

REQUESTED BY: Jenna Shaw-Battista, PhD, RN, PHN, NP, CNM, FACNM
Chair

BACKGROUND:

The members of NMAC will discuss any trends/issues with final dispositions of disciplinary cases against CNMs. Discipline data for the past seven (7) years is included in the two charts below:

Certified Nurse-Midwife (CNM) Discipline Statistics

Type of Discipline	2018	2019	2020	2021	2022	2023	2024	2025 (as of 2/25/25)
Public Reproval	1	0	1	0	0	0	0	0
Probation	2	4	2	0	0	0	0	0
Surrender	1	1	1	0	1	0	1	0
Voluntary Surrender during Probation	1	1	1	1	0	2	0	0
Revocation	0	0	1	1	1	0	2	0
Reinstatement	0	0	0	0	0	0	0	0
Total	**5**	**6**	**6**	**2**	**2**	**2**	**3**	**0**

CNM Discipline Statistics – Violation Types

Violation Type	2018	2019	2020	2021	2022	2023	2024	2025 (as of 2/25/25)
Practice	2	3	4	0	2	0	1	0
801 Practice	1	1	0	1	0	0	0	0
OSD	0	1	0	0	0	0	0	0
Conviction	1	0	1	0	0	0	2	0
SUD	0	0	0	0	0	0	0	0
Sexual Misconduct	0	0	0	0	0	0	0	0
Other	1	1	1	1	0	2	0	0
Total	**5**	**6**	**6**	**2**	**2**	**2**	**3**	**0**

RESOURCES:

BRN Disciplinary Guidelines: https://www.rn.ca.gov/pdfs/enforcement/discguide.pdf

NEXT STEPS:

FISCAL IMPACT, IF ANY: None

PERSON(S) TO CONTACT:

McCaulie Feusahrens
Chief of the Licensing Division
California Board of Registered Nursing
mccaulie.feusahrens@dca.ca.gov

Agenda Item 7.0

Discussion and possible action: Update on the revisions to the BRN website regarding the passage of SB 667 (Reg. Sess. 2022-2023), including NMAC updates on the Frequently Asked Questions document

Nurse-Midwifery Advisory Committee (NMAC) Meeting | March 18, 2025

BOARD OF REGISTERED NURSING
Nurse-Midwifery Advisory Committee Meeting
Agenda Item Summary

AGENDA ITEM: 7.0
DATE: March 18, 2025

ACTION REQUESTED: **Discussion and possible action:** Update on the revisions to the BRN website regarding the passage of SB 667 (Reg. Sess. 2022-2023), including NMAC updates on the Frequently Asked Questions (FAQ) document

REQUESTED BY: Jenna Shaw-Battista, PhD, RN, PHN, NP, CNM, FACNM
Chair

BACKGROUND:

The NMAC will discuss the revisions to the BRN website, and any updates needed to the FAQ document.

RESOURCES:

FAQs related to midwifery practice and the implementation of Senate Bill (SB) 1237 (Reg. Sess. 2019-2020)**:** https://www.rn.ca.gov/pdfs/regulations/nmwfaqs_sb1237.pdf

NEXT STEPS:

FISCAL IMPACT, IF ANY: None

PERSON(S) TO CONTACT: McCaulie Feusahrens
Chief of the Licensing Division
California Board of Registered Nursing
mccaulie.feusahrens@dca.ca.gov

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 incident 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)