



MEDICAL BOARD OF CALIFORNIA Licensing Program



MIDWIFERY ADVISORY COUNCIL

December 3, 2015

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

MEETING MINUTES

Agenda Item 1 **Call to Order/Roll Call**

The Midwifery Advisory Council (MAC) of the Medical Board of California (Board) was called to order by MAC Chair Carrie Sparrevohn at 1:00 p.m. A quorum was present and notice was sent to interested parties.

Members Present:

Carrie Sparrevohn, L.M., Chair
Karen Ehrlich, L.M.
Tosi Marceline, L.M.
Barbara Yaroslavsky
James Byrne, M.D.

Staff Present:

Diane Dobbs, Department of Consumer Affairs, Legal Counsel
Kimberly Kirchmeyer, Executive Director
Natalie Lowe, Licensing Manager
Elizabeth Rojas, Staff Services Analyst
AnnaMarie Sewell, Associate Governmental Program Analyst
Jennifer Simoes, Chief of Legislation
Kerrie Webb, Legal Counsel
Curtis Worden, Chief of Licensing

Members of the Audience:

Bruce Ackerman, Midwives Alliance of North America
Kayti Buehler, California Association of Midwives
Rosanna Davis, L.M., California Association of Midwives
Andrea Ferroni, L.M.
Rachel Fox-Tierney, L.M.
MacKenzie Hardwick
Diane Holzer, L.M.
Kaleem Joy, L.M.
Rachel Kiene, L.M.
Lesley Nelson, L.M.
Shannon Smith-Crowley, American College of Obstetricians and Gynecologists

Linda Walsh, California Nurse-Midwives Association
Sue Wolcott, L.M., Shasta Midwives

Agenda Item 2 **Public Comment on Items not on the Agenda**

Ms. Sparrevohn stated that Ms. Monique Webster had resigned from the MAC public member position on November 23, 2015, and the position would be noticed for the March MAC meeting.

Ms. Rosanna Davis commented that El Camino Hospital in Mountain View, CA was unaware of the Transfer of Planned Out-of-Hospital Delivery to Hospital Reporting Form and requested information be provided to the hospital.

Ms. Buehler suggested that a report regarding the consistent lack of collaboration and consultation that is available be placed on the agenda for the next MAC meeting.

Agenda Item 3 **Approval of the August 13, 2015 Midwifery Advisory Council Meeting Minutes**

Ms. Marceline provided an edit to strike the word “vaginally” on page five, in the second paragraph of the meeting minutes.

Ms. Sparrevohn made a motion to approve the August 13, 2015 meeting minutes with edits; s/Ms. Ehrlich. Motion carried unanimously.

Agenda Item 4 **Report from the Midwifery Advisory Council Chairperson**

Ms. Sparrevohn requested the support and assistance of the Board to provide resources in order to organize a midwifery college education program.

Ms. Kirchmeyer stated that staff can identify the entities that the MAC could contact for approval, of schools such as the Bureau of Private and Post-Secondary Education.

Ms. Sparrevohn suggested that individuals who are interested in organizing a midwifery college education program contact her.

Agenda Item 5 **Implementation of Senate Bill 408 Midwife Assistants**

Ms. Simoes stated that Senate Bill (SB) 408 was signed into law by the Governor to ensure midwife assistants meet minimum training requirements. The implementation plan is to hold an Interested Parties meeting and to draft regulations regarding the training requirements by the end of January 2016. The proposed regulations will be presented at the March 2016 MAC meeting for input, and then presented for approval at the May 2016 Board meeting with a possible regulation hearing at the July 2016 Board meeting.

Agenda Item 6 **Update on Implementation of Assembly Bill 1308**

Ms. Webb indicated that Assembly Bill (AB) 1308 focuses on regulations that need to be put into place pursuant to Business and Professions Code (B&P) section 2507. Ms. Webb stated that a meeting was held with the California Association of Midwives (CAM) and the American College of Obstetricians and Gynecologists (ACOG), but it was unproductive in moving the issue forward. Ms. Webb stated that CAM suggested a compromise by putting limitations on some types of vaginal births after cesarean (VBAC), but ACOG wanted every woman who is contemplating a VBAC at home to have a physician consult first.

Ms. Sparrevohn questioned if more Interested Parties meetings would be planned for this topic.

Ms. Webb stated that there were no meetings currently planned.

Ms. Sparrevohn questioned if it was mandatory to have consensus before moving forward with regulation.

Ms. Webb indicated that it was not mandatory to have complete consensus prior to moving forward with the regulations; however, the problem is with the science and the language of the statute, specifically with the language “likely to have an impact on the course of the pregnancy and delivery.” Ms. Webb stated that both sides see the science very differently.

Ms. Sparrevohn stated that she would be in favor of moving forward in a way that validates the low risk nature of a VBAC with one prior cesarean, and thought CAM was advocating for that as well.

Dr. Byrne stated that when someone seeks a consultation with a physician, they are free to disregard the recommendation.

Ms. Sparrevohn indicated that midwives are not free to disregard the physician recommendation, and the law states the physician must indicate the condition is not likely to impact the pregnancy or birth, or midwives cannot care for the woman.

Dr. Byrne referred to agenda item two and stated there was concern regarding access to care in local communities. Dr. Byrne stated that he had reached out to the Office of Statewide Health Planning and Development (OSHPD) to receive information from the Licensed Midwife Annual Report (LMAR) in order to review the data for VBACs in the prior year and link it to the county data. Dr. Byrne found that the LMAR does not currently show the counties in which VBACs are performed, and requested the LMAR be revised to collect that type of data.

Ms. Ehrlich responded that Dr. Byrne’s request was addressed in the recommended revisions to the LMAR that had been previously submitted. In the meantime, it prevents women from receiving the care they want, and preventing midwives from providing care that is within their scope of practice.

Dr. Byrne stated that when assessing risk for prior VBACs it is a low risk for uterine rupture.

Ms. Ehrlich stated that when speaking of birth and taking care of healthy women in general, with the exception of prior cesareans, there is always a risk factor. Ms. Ehrlich indicated that the risk for VBAC women with one prior cesarean is not higher than women who have never had a birth.

Ms. Yaroslavsky indicated that information should be based on facts, and that by obtaining factual information it allows for a stronger ability to make a good decision.

Ms. Ehrlich stated she was concerned with the barriers that will occur if they do not move forward with allowing licensed midwives to care for women with one prior cesarean.

Dr. Byrne indicated that it would help justify the movement that Ms. Ehrlich was seeking if more data was available to show that it really was beneficial.

Ms. Marceline commented that things change year by year, and when data is captured for a previous year it may not reflect the current situation. Ms. Marceline stated that procedures performed in hospitals and at home for a woman who is having a VBAC will impact whether she is more or less likely to rupture. Ms. Marceline provided an example stating that many hospitals feel that low doses of Pitocin, to either induce or augment a woman's labor if she is having a hospital birth and a VBAC, seem to be in their scope of practice, but it is definitely not in the licensed midwives scope of practice; therefore, there will be a different rate of rupture in home birth cliental than in hospital birth cliental.

Ms. Marceline stated that some women will choose to have a VBAC in a hospital setting, that may not be appropriate for a home birth setting, and that is where the licensed midwife is counseling and selecting her cliental carefully.

Dr. Byrne stated that if the rate was lower with better management, maybe it would cut the risk down four fold so that the risk of uterine rupture is 1 out of 1000, and in the event that it does happen, it is potentially a catastrophic injury. Dr. Byrne stated that it is an issue of what is predictable or what is preventable. Dr. Byrne added that he thought clarity of information and a balanced approach would be the strongest approach.

Ms. Sparrevohn stated that she had analyzed the LMAR data and reviewed every outcome since 2007, that might be attributed to a VBAC gone badly and even when she did that, the outcomes were really good. Ms. Sparrevohn indicated that overall midwife statistics are good, which points to the fact that midwives are not having a lot of problems with VBACs specifically. Ms. Sparrevohn asked how a consult with an obstetrician would change the outcome for any woman that has had one prior cesarean.

Dr. Byrne stated it would not change the outcome. Dr. Byrne indicated that if there is a potential client that is not a mutually assessed good candidate for VBAC, with four prior cesareans, in some ways that information is beneficial coming from a physician, because it is probably not welcomed news, and hearing it from a different voice might help. He thought that from the aspects of informed decision making and clarity, there are a few things that are predictable or preventable for such a catastrophic outcome.

Dr. Byrne stated that according to the 2014 LMAR data, VBAC is a relatively small number, and instead of throwing in the towel, he asked if it is worth delaying the entire initiative over one issue, or can that one component be parked and agreed upon at a later date since it seems that this is an impasse point.

Ms. Sparrevohn questioned if it would be possible to place a condition in the regulation allowing changes to the LMAR in order to capture data, and allow for the time being, one prior cesarean with a documented low transverse incision to not require a physician consult, and the regulation be reevaluated at a specific date in order to capture historical data.

Ms. Webb indicated that the suggestion of going forward with regulations with some limitation on VBAC, but not a total limitation without a physician consult, is not something ACOG seems open to at this time.

Ms. Sparrevohn questioned if ACOG could agree to that sort of condition, could it be legally placed in the regulations.

Ms. Webb indicated that it could be done.

Dr. Byrne suggested to include VBAC as a high risk condition and to allow ongoing review and reassessment at a later date.

Ms. Ehrlich questioned if it would still be required that the woman see a physician.

Dr. Byrne confirmed that the woman would still need to see a physician to document if there was an impact on access of care and impact on choice.

Ms. Ehrlich stated that for a couple of decades women have had the right to have their VBACs at home with licensed midwives and stated that what will happen is that right will be taken away and then maybe given back in the future. Ms. Ehrlich felt it should be the other way around since it is historically something that has been the scope of midwifery practice and it needs to be included with further review of being reasonable.

Ms. Ehrlich requested to review the existing information being captured in studies throughout the United States, and take that data into account when trying to eliminate the right of pregnant women.

Ms. Yaroslavsky stated that since there is no data for VBACs being collected for midwives or hospitals, the discussion should not occur until the data is received.

Dr. Byrne commented that OSHPD has the data for hospitals, and added that the clarity would be helpful.

Ms. Ehrlich stated that she objects taking something away from women that they already have, without indication that it is dangerous to the ones making that choice with full and informed consent by midwives.

Ms. Sparrevohn provided an overview of the regulation that was enacted in 2005 regarding VBAC. Ms. Sparrevohn indicated that when midwives originally adopted the Standard of Care for Licensed Midwives, VBACs were allowed with specific requirements of what had to be in the consent, and one of those things was ACOG's position statement on VBACs. Ms. Sparrevohn stated that the Standard of Care written in 2005 was a way to make sure that women having a home VBAC, or even considering a VBAC, would get consistent information from midwives. Ms. Sparrevohn stated that with the enactment of AB 1308 it went away because the legislation that authorized that regulation got eliminated as part of AB 1308. Ms. Sparrevohn concluded that the MAC was required to create a new regulation, which was currently at an impasse, even though the previous regulation that was in place was working fine and everybody had agreed to it in 2005.

Ms. Smith-Crowley stated that ACOG did not agree to the regulation, and what the Board did was illegal. Ms. Smith-Crowley stated that the Board was not content with ACOG and California Medical Association (CMA) for including physician supervision into the law.

Ms. Smith-Crowley questioned how many times other licensed professionals were allowed to waive the scope of practice. Ms. Smith-Crowley stated a patient cannot agree to have their physician assistant do their appendectomy, or do their open heart surgery, as there are parameters. Ms. Smith-Crowley stated that the only reason the regulation went through is because ACOG decided not to sue. Ms. Smith-Crowley stated that the regulation was extremely problematic for ACOG, and as a concession to ACOG, the Board indicated that the ACOG document would be required to be given to women. ACOG saw the hand writing on the wall that ACOG was not winning. ACOG did not want to sue and thought it would be able to clean it up later.

Ms. Smith-Crowley stated that to set the record straight, ACOG has not supported home VBACs. Ms. Smith-Crowley concluded that the legislation that went through was something that the author decided was important, and ACOG felt they had reached a reasonable compromise by having a physician examination to discuss how physicians expected the course of the pregnancy to go, whether the woman was a good candidate or not, and that it had nothing to do with home births.

Ms. Sparrevohn indicated that she attended the same meeting and recalls that ACOG wrote the regulation. Ms. Sparrevohn felt that everyone understood at the time that ACOG was not endorsing home VBACs; however, the MAC, the Board, and ACOG agreed to the regulation and ACOG authored it.

Ms. Smith-Crowley indicated that the Board did allow ACOG to have input and she can provide the letter that was written to the Office of Administrative Law indicating ACOG thought the regulation exceeded the statute.

Ms. Ehrlich commented that whatever was true or not in 2005, it was currently in the midwives' scope of practice to perform VBACs, and she thought that the regulation should be reinstated and it would meet the approval of the midwives in California.

Dr. Byrne requested clarification regarding a waiver process that allowed the patient to disregard the VBAC counseling.

Ms. Sparrevohn stated that it was an old process, and it was removed due to AB 1308. Ms. Sparrevohn indicated that the waiver was not specific to VBACs, it was a clause in the Standard of Care that allowed midwives to continue to care for a woman with potentially higher risk conditions as long as the woman was well informed, and she confirmed that she was informed, and then she would continue to birth at home with a midwife.

Ms. Ehrlich indicated that it was moderate risk, and it did not include high risk in the regulation.

Ms. Sparrevohn commented that she understood Ms. Smith-Crowley's statement, that perhaps ACOG agreed to do the specific VBAC regulation because there was a clause in the Standard of Care.

Ms. Smith-Crowley indicated that ACOG was not winning and that was a modification that provided more protection. Ms. Smith-Crowley stated that there is need for statutory changes to indicate a woman will need a physician consult, and the physician provides a discussion about VBAC, and not having a specific sign off. Ms. Smith-Crowley thought a physician consult would ensure there is a medical evaluation of a woman who is potentially at a higher risk.

Ms. Ehrlich suggested changing the statement from "higher risk" to "moderate risk" because if "higher risk" is placed into statute it will remove the right for women in California.

Dr. Byrne questioned what guidance there was from countries where home births are part of their national healthcare and how those countries, such as the Netherlands or the United Kingdom, approach the location of VBACs in counseling.

Ms. Marceline indicated that in the United Kingdom, if a mother is asking for something that the midwife feels is dangerous, and the mother is given informed consent, the mother has the last say. The midwife cannot refuse care because it is more dangerous for a mother to give birth alone.

Ms. Sparrevohn thought that the recommendation in the United Kingdom is to VBAC in a hospital, and in terms of the Netherlands, she was unsure.

Ms. Sparrevohn encouraged groups to find a middle ground.

Ms. Yaroslavsky inquired as to who would be responsible for meeting and agreeing on the terms of the regulations.

Ms. Sparrevohn stated that the agreement will need to happen between CAM and ACOG since the Board has done what it can in terms of Interested Parties meetings. Ms. Sparrevohn concluded that if regulations were going to be drafted for AB 1308 there would have to be movement, and if regulations are not drafted licensed midwives will not be able to provide Medi-Cal services in a birth center.

Agenda Item 7 **Licensed Midwife Annual Report Taskforce**

Ms. Lowe provided an update on the Interested Parties meeting that was held on October 13, 2015, to discuss possible revisions of the LMAR reporting tool. The meeting provided an open discussion on the requests and needs of licensed midwives and other interested parties on how the future statistics would

be collected and what data elements would be included. Following the meeting Board staff met with OSHPD staff to discuss the project and what roles and responsibilities each agency would have. It was determined that there were several items that would need additional research and review prior to completing a design document for recommendation to the Board. Ms. Lowe noted that one major area of concern for both Board staff and OSHPD was how data would be reported: whether it would be reported prospectively, or an accumulative report that captures the previous year's data as it is currently being done.

Ms. Lowe stated in addition to the comments provided at the Interested Parties meeting, Board staff felt it would be beneficial to obtain feedback from all licensed midwives in California on the matter, before proceeding with the design of the new system. Ms. Lowe indicated that a survey would be sent to all licensed midwives requesting feedback on the LMAR, and based on the information received; the Board would have a better understanding of the needs of all licensed midwives in California.

Ms. Lowe noted that moving to an online system, where data is reported prospectively, would allow for additional statistics to be captured relatively easy for the midwife. However, if it is agreed to move to a prospective data system, staff would need to take into consideration midwives that would be reporting on paper, and midwives that would be reporting previous years of data that could not utilize the online system.

Ms. Yaroslavsky requested that all the MAC members receive a copy of the questionnaire as some of the members were not midwives.

Ms. Yaroslavsky stated that if access to computers is an issue then staff should inform midwives of free online services that are available, for example, public access to computers at county libraries. Ms. Yaroslavsky suggested adding a question to the survey asking if there is free Wi-Fi service in a nearby public facility for the use of a midwife to complete the LMAR.

Dr. Byrne questioned if there is a precedent with other groups under the Board where one would have both options, and there would be a different fee structure for those who desire to submit a paper format.

Ms. Kirchmeyer responded that the Board must offer the document in paper and online. Ms. Kirchmeyer added that in order for the Board to require midwives to use an online program, the Board would need legislation.

Ms. Sparrevohn hoped that the midwifery organizations and midwifery networks could relay the message that being able to utilize the online prospective data collection system would benefit midwives and maybe midwives could encourage colleagues to utilize computers.

Ms. Marceline asked if midwives would need the consent of the mothers they care for in order to enter their data if the reporting requirements changed.

Ms. Lowe indicated that OSHPD is prohibited from collecting personal identifying information. The new system would automatically assign the patient a random identification number that the midwife could include in the chart, and would use to enter the information into the system. Ms. Lowe stated that the Board hopes there is a strong agreeance that reporting prospectively would be ideal and that an

online system would be the best way to report the data. However, if the survey indicates that the majority of the midwives decide not to report prospectively then the method to report will be readdressed.

Ms. Ehrlich requested to include the question, "Have you submitted your previous LMARs? If not, why and what would help to trigger you to actually do it?" in the survey.

Mr. Ackerman commented that the paper data forms used with the Midwives Alliance of North America (MANA) statistics system were extremely troublesome. In 2009, MANA found that only three midwives nationwide used the paper version and when staff at MANA spoke to those midwives individually, the midwife indicated that they had not gotten around to completing the reporting. Since then, MANA phased out the paper form.

Mr. Ackerman suggested that an improvement would be to repeal the legislation that is enabling the LMAR, and start collecting data through the MANA statistics.

Ms. Sparrevohn stated that she is aware of discussions relating to the MANA statistics project being moved to an entity that is not associated with MANA so that it would not be part of a professional organization and questioned the status of that process.

Mr. Ackerman indicated that the process will occur through a period of a few years, and the details have not been sorted out.

Ms. Smith-Crowley questioned if the MAC was aware of the new maternal data center with the State and if not, to view the California Maternal Quality Care Collaborative (CMQCC) website at www.cmqcc.org to review the integrated data with the Maternal Data Center. Ms. Smith-Crowley stated that the organization and the data they collect for quality improvement campaigns has reduced the maternal death rate by half in a handful of years. Ms. Smith-Crowley stated that the way the MAC is trying to integrate the care with physicians and midwives, is the way the MAC should look at the Maternal Data Center. Ms. Smith-Crowley stated that if the data goes through OSHPD, to the Maternal Data Center, and the Maternal Data Center could get information from Vital Statistics this would pull the data from everywhere. Part of the issue is that it is easier to figure out the pregnancy related deaths that are within the first 42 days, but it is more difficult to pull the information for the pregnancy associated deaths that are within the year. Ms. Smith-Crowley stated that whoever is completing the birth certificate has no clue that a woman had a birth within the last year, but when the data goes through the Maternal Data Center they are able to pull that data out.

Ms. Smith-Crowley stated that in looking at the data, if one is trying to figure out what is real and what is not, the Maternal Data Center is the one that can do it. Ms. Smith-Crowley stated it was collaborative when the Maternal Data Center worked on the first maternal death review and added that in 2006. The Maternal Data Center went through every maternal death in the state and completed a root cause analysis, and found that 40% of hospitals did not have a hemorrhage protocol in place.

Ms. Smith-Crowley stated that since there was not a protocol in place, the Maternal Data Center stopped the review and collaboratively wrote best practices. Ms. Smith-Crowley concluded that there are benefits of having data go through OSHPD, and the Maternal Data Center.

Ms. Sparrevohn stated that she thought, as they discussed using the MANA statistics project, that the data would always be funneled through OSHPD.

Mr. Ackerman indicated that was his understanding as well and shared that currently in Washington State all hospitals are using MANA statistics, the statistics go directly from the MANA data set to Obstetrics Clinical Outcomes Assessment Program (OB COAP).

Ms. Ehrlich requested Ms. Smith-Crowley to lobby for a home birth midwife with CMQCC.

Ms. Smith-Crowley agreed with Ms. Ehrlich and confirmed that she would do so.

Ms. Marceline recommended getting rid of the LMAR, and to utilize the new reporting system if it is going to be prospective since it can increase a sense of how well midwives are doing and where midwives need to improve.

Ms. Ferroni stated that she hoped Mr. Ackerman would speak more on the Washington MANA statistics collection that the licensed midwives in Washington use, that goes directly into their version of the CMQCC. Ms. Ferroni commented that she felt it addresses the problems with the data collection and the ability to assess how licensed midwives are doing for the hot topics such as VBAC. Ms. Ferroni concluded that it brings midwives into the big picture of quality improvement as maternity care providers and felt that the MAC should be focusing on that topic.

Agenda Item 8 **Program Update**

A. Licensing Statistics

Ms. Lowe provided an update on the licensing statistics stating that staff included the breakdown on the status of licenses at the end of the fiscal year which was requested by the MAC. Ms. Lowe noted that the data reflects the total licensing population at the end of each fiscal year, and it is important to recognize that the data is not a cumulative total.

B. Enforcement Statistics

Ms. Lowe provided an update on the enforcement statistics indicating that the data was separated to show licensed midwives and unlicensed midwives per the request of the MAC. Ms. Lowe hoped the data was clear since it shows the respective data for the two different data sets. Ms. Lowe stated that staff also removed the unlicensed midwives hospital reporting forms, and the data will only show hospital reporting forms for licensed midwives.

Ms. Sparrevohn questioned if the Board is receiving hospital reporting forms from unlicensed midwives with their names.

Ms. Lowe indicated the Board is not receiving reporting forms from unlicensed midwives and since staff separated unlicensed enforcement activity at the top from licensed and unlicensed, there will not be two separate reporting areas for the hospital reporting forms.

Ms. Sparrevohn asked if there might be an investigation that is opened as a carry over and how can they view that data.

Ms. Kirchmeyer indicated that an opened investigation is shown for a specific timeframe, and staff would need to add a line to show what open investigations are still pending.

Ms. Sparrevohn requested to add a line to show the data for pending investigations.

Agenda Item 9 **Future Midwifery Advisory Council Meeting Dates**

After discussion by the MAC, the proposed dates for the 2016 MAC meetings will be March 10, 2016, August 18, 2016, and December 1, 2016.

Ms. Sparrevohn made a motion to approve the 2016 MAC meeting dates; s/Ms. Yaroslavsky. Motion carried unanimously.

Agenda Item 10 **Agenda Items for the Next Midwifery Advisory Council Meeting in Sacramento**

- Report from the MAC Chair
- Update on Midwifery Legislation
- Update on LMAR Task Force
- Update on AB 1308 Regulation
- MAC Membership
- Update on Midwife Assistant Regulation
- Discussion of Reporting on Home Birth/VBACs from Other Countries
- Discussion on Consistent Lack of Collaboration and Consultation

Agenda Item 11 **Adjournment**

Ms. Sparrevohn adjourned the meeting at 2:49 p.m.

The full meeting can be viewed at [http://www.mbc.ca.gov/About Us/Meetings/2015/](http://www.mbc.ca.gov/About_Us/Meetings/2015/)



MEDICAL BOARD OF CALIFORNIA

Licensing Program

MIDWIFERY ADVISORY COUNCIL

March 10, 2016

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

MEETING MINUTES

Agenda Item 1 Call to Order/Roll Call

The Midwifery Advisory Council (MAC) of the Medical Board of California (Board) was called to order by MAC Chair Carrie Sparrevohn at 1:00 p.m. A quorum was present and notice was sent to interested parties.

Members Present:

Carrie Sparrevohn, L.M., Chair
Karen Ehrlich, L.M.
Tosi Marceline, L.M.
Barbara Yaroslavsky

Members Absent:

James Byrne, M.D.

Staff Present:

April Alameda, Staff Services Manager II
Ramona Carrasco, Staff Services Manager I
Dianne Dobbs, Legal Counsel, Department of Consumer Affairs
Natalie Lowe, Staff Services Manager I
Elizabeth Rojas, Staff Services Analyst
AnnaMarie Sewell, Associate Governmental Program Analyst
Jennifer Simoes, Chief of Legislation
Kerrie Webb, Legal Counsel
Curtis Worden, Chief of Licensing

Members of the Audience:

Anne Marie Adams, M.D.
Kate Bowland, C.N.M., California Nurse-Midwife Association
Phyllis "Kayti" Buehler, California Association of Midwives
Pauline Carr
Rosanna Davis, L.M., California Association of Midwives

Jocelyn Dugan
Rachel Fox-Tierney, L.M.
Chelsea Fredlund, L.M.
Faith Gibson, L.M., California College of Midwives
Laurie Gregg, M.D., American College of Obstetricians and Gynecologists
Kiki Jordan, L.M., Marin Family Birth Center
Kaleem Joy, L.M.
Rachel Kiene, L.M.
Rebekah Lake, L.M.
Sandra Mendez, M.D.
Nancy Myrick, C.N.M.
Lesley Nelson, L.M.
Laura M. Perez, L.M., Bay Area Midwifery
Shannon Smith-Crowley, American College of Obstetricians and Gynecologists
Linda Walsh, C.N.M., California Nurse-Midwife Association
Martine Wilson
Melissa Wiseman, L.M., Thrive Birth Center

Agenda Item 2 **Public Comment on Items not on the Agenda**

Ms. Rosanna Davis requested the opportunity to make a presentation at the next MAC meeting on the Quality Care Program for California licensed midwives.

Agenda Item 3 **Approval of the December 3, 2015 Midwifery Advisory Council Meeting Minutes**

Ms. Sparrevohn motioned to table the December 3, 2015 meeting minutes until the August 18, 2016 MAC; s/Ms. Ehrlich. Motion carried unanimously.

Agenda Item 4 **Report from the Midwifery Advisory Council Chairperson**

Ms. Sparrevohn stated that in the interest of time she would not be providing a report.

Agenda Item 5 **Report Regarding the Ability of Licensed Midwives to Consult or Collaborate as Required by AB 1308**

Ms. Rosanna Davis provided a presentation titled, “A Survey: Challenges of Licensed Midwives Referrals to Physicians” that outlined some of the difficulties licensed midwives (LM) face, including securing timely care for clients, the availability of ultra sounds, the willingness of obstetricians to accept referrals, and the expense for clients.

Following the presentation, Ms. Davis stated that the California Association of Midwives (CAM) and California Association of Licensed Midwives (CALM) are bifurcating into two organizations so that the second organization could focus on the professional needs of California licensed midwives. Ms. Davis added that plans were being made to create a Comprehensive

Quality Care Program which would include their own professional standards of care and proactive communication with hospitals.

Ms. Yaroslavsky referred to the presentation and suggested having a follow-up survey that would include demographics.

Ms. Ehrlich suggested adding questions to the survey to inquire how many clients are Medi-Cal eligible, and how many are self-paid.

Ms. Davis stated that CAM is in need of more people to reach out to hospitals and doctors regarding the challenges of LM referrals to physicians, and suggested placing an article in the Board's Newsletter.

Ms. Yaroslavsky stated that, in the past, disseminating information by PowerPoint to local hospitals received positive outcome. Ms. Yaroslavsky thought that the model was excellent, and should be used as a resource to help devise a program.

Ms. Smith-Crowley stated that the American College of Obstetricians and Gynecologists (ACOG) would be willing to work with CAM on a local level, and suggested looking at the geographic areas as it may vary on the physician's liability coverage. Ms. Smith-Crowley stated that the University of California, San Francisco, has also indicated that they would be willing to provide assistance as well.

Ms. Smith-Crowley stated that most women should have coverage under the Affordable Care Act, Medi-Cal, or a commercial insurance. She added that it would be interesting to see how many do not have Medi-cal or a commercial insurance as they would be penalized for not having it.

Ms. Marceline stated that she thought the issue was the high deductible, which does nothing for the client, and the second issue was managed care. Ms. Marceline stated that managed care does not cover the cost of midwifery services, and women could receive managed care at a lower cost by going to a midwife. Ms. Marceline added that women who choose to use Medi-Cal can request their worker opt out of managed Medi-Cal and get straight Medi-Cal, but are often denied.

Ms. Smith-Crowley concurred with Ms. Marceline and indicated that it is ACOG's reality as well, and that ACOG has a specific group that could work on the issue.

Ms. Ehrlich indicated that she ran into an issue in the past where insurance companies would not cover home birth.

Ms. Smith-Crowley agreed with Ms. Ehrlich, indicating that insurance companies that do not cover home births are an issue, but she was referring to problems relating to failure to receive a referral because of odd insurance issues.

Ms. Sparrevohn questioned if ACOG would be willing to work with CAM/CALM to provide presentations for physicians to help with receptivity.

Ms. Smith-Crowley stated that ACOG would be willing to work with CAM/CALM.

Agenda Item 6 **Update on Midwife Assistant Regulations**

A. Discussion and Approval of Proposed Midwife Assistant Regulations

Ms. Lowe provided an update on the proposed midwife assistant regulations stating that on February 3, 2016 an Interested Parties meeting was held to discuss regulations needed to define the training requirements for midwife assistants to practice in California. Ms. Lowe stated that Business and Profession Code section 2516.5 went into effect on January 1, 2016, requiring a midwife assistant to obtain a minimum amount of hours of appropriate training pursuant to the standards established by the Board for a medical assistant.

Ms. Lowe stated that the medical assistant regulations were used as a starting point to draft the regulations for a midwife assistant. During the Interested Parties meeting each item was discussed individually to determine what the appropriate training should be for each task outlined in the scope of practice. Following the meeting, Board staff gathered all of the information provided to create the proposed midwife assistant regulations.

Ms. Lowe pointed out that staff included the language for educational programs in the proposed regulations so that if a program is created in the future the regulations would allow for this. Ms. Lowe stated that this would include providing a pathway to obtain training through a program, as well as, approving the certifying organization.

Ms. Lowe concluded that staff would be making some minor edits to the language that was presented at the meeting, which included: adding “Certified Nurse-Midwife” to sections 1379.01, 1379.05, 1379.06 (a)(1) and (b); updating the title to read “Bureau of Private Postsecondary Education,” in section 1379.06; as well as updating the appropriate section of law, and striking the words “and Vocational” from section 1379.07 (b)(3)(B).

Ms. Yaroslavsky motioned to present the proposed midwife assistant regulations, with edits, to the full Board for approval; s/Ms. Sparrevohn. Motion carried unanimously.

B. Discussion on Utilization of a Midwife Assistant Prior to the Approval of Midwife Assistant Regulations

Ms. Webb indicated that prior to the approval of the midwife assistant regulations, a midwife may utilize a midwife assistant who has been trained pursuant to Business and Professions Code section (B&P) 2069, and regulations related to that section, as it would meet the requirement of having the minimum amount of hours of appropriate training pursuant to standards established by the Board for a medical assistant.

Ms. Sparrevohn questioned if midwives could utilize a medical assistant in a capacity of a midwife assistant.

Ms. Dobbs clarified that B&P 2516.5(b) outlines what a midwife assistant may do. Ms. Dobbs stated that those items that are delineated in the statute that are clear do not need regulations since it is already clearly placed in the statute. Certain items that are not clear, staff would create the regulations to make those items specific. Until regulations pass, anything that is already delineated in the statute goes into effect today. Ms. Dobbs added that if a midwife has someone who has the training of a medical assistant, then they may utilize them.

Ms. Sparrevohn questioned if didactic training could be done in the interim for midwife assistants who have no prior training.

Ms. Webb stated that midwives may provide didactic training, but the midwife may not know what would be required in regulation.

Agenda Item 7 **Update on Implementation of Assembly Bill 1308**

Ms. Webb provided an update on Assembly Bill (AB) 1308 stating that ongoing discussions are still in place between the midwifery community and ACOG. Ms. Webb stated that there has been interest in moving forward with the regulations, even if it means having a physician consult prior to every vaginal birth after cesarean (VBAC).

Ms. Webb stated that she was not sure if that opinion was representative of the majority of the midwives, which is still being explored. Ms. Webb stated that other legislative changes are being explored that require a consult, but not requiring a physician to sign off. Ms. Webb added that nothing is set in writing, but felt there was positive movement.

Ms. Ehrlich stated she is unclear on what the process is, that is now being advocated.

Ms. Webb stated that there could be a change in how avid the midwifery community has been about no prior physician consult for certain categories of VBACs. Ms. Webb stated that there could be flexibility to have a physician consult and then what that entails could be explored.

Ms. Ehrlich stated that anything required of midwives and their patients would not work unless it is also required of the physicians. Ms. Ehrlich stated that if physicians are not required to give consults or accept referrals then it would not work.

Ms. Webb stated that she thought the presentation by CAM was nice to see, based on those who responded, as it indicates that collaborative relationships are possible and could be fostered.

Ms. Marceline requested to hold an interested parties meeting to hear the opinions of women.

Ms. Yaroslavsky suggested that along with an interested parties meeting, collaboration should be attempted, as it has been made clear during the meeting by both ACOG and CAM, that there are areas of the state where collaboration is occurring.

Ms. Sparrevohn stated that everyone needs to come together so that physicians, hospitals, and midwives are working together to provide safe informed care, regardless of the setting and provider. Ms. Sparrevohn indicated that it could only be done if midwives foster those relationships and not dismiss the possibility of it ever happening. Ms. Sparrevohn questioned if staff could schedule another interested parties meeting regarding AB 1308.

Ms. Webb stated that she would raise the question with Board staff.

Dr. Mendez suggested that medical malpractice carriers should be included in the conversation as they are limiting individuals to participate in home births. Dr. Mendez thought that there is a third prong in the information, which is to go to the malpractice carriers and educate them as to what certified and licensed midwives do.

Agenda Item 8 **Update on Licensed Midwife Annual Report (LMAR) Taskforce**

Ms. Lowe provided an update on the Licensed Midwife Annual Report (LMAR) stating that at the December 3, 2015 meeting, an update on the LMAR Taskforce was provided indicating that prior to designing a document staff would be sending a survey to all licensed midwives and interested parties. Unfortunately, staff was unable to complete the task due to limited resources. Ms. Lowe stated that the survey would be sent soon and an update would be provided at the next MAC meeting.

Agenda Item 9 **Midwifery Advisory Council Membership**

Ms. Lowe stated that in January 2016, Board staff sent notice to all licensed midwives, subscribers on the Board's subscriber's alert list, and posted information on the Board's website, to announce that the Board was seeking applications from licensees and interested parties to fill three positions on the MAC.

Ms. Lowe indicated that the vacancies included one licensed midwife, one licensed physician and surgeon, and one public member position. Ms. Lowe stated that staff had received seven applications for the physician and surgeon vacancy, six applications for the public member vacancy, and zero applications for the licensed midwife vacancy. Because no applications were received for the licensed midwife vacancy, the Board would be re-advertising the position and applications would be provided at the next MAC meeting.

Ms. Lowe presented the vacancy for the physician and surgeon position, a three-year term, set to expire June 30, 2019. The seven applications received for the licensed physician and surgeon vacancy were from: Dr. Anne Marie Adams, Dr. Jeffery Martin, Dr. Sandra Mendez, Dr. Enrico Pietrantonio, Dr. David Priper, Dr. Donna Richie, and Dr. Alex Sophici. Ms. Lowe asked if any applicants in attendance would like to address the MAC.

Dr. Mendez introduced herself as an Ob/Gyn in private practice since 1990. Dr. Mendez stated that she delivers at Methodist Hospital in South Sacramento, and her practice has been very highly Medi-Cal populated. She is bilingual, and has a high Spanish-speaking population. Her

interest in being on the MAC is to promote more collegiality among everyone, starting with the idea that our premises is safe, and what is best for mothers and babies is being delivered. Dr. Mendez felt that if everyone focused on collaboration, that everyone could come to a consensus of what is the best practice.

Dr. Adams introduced herself and stated that she has been practicing in the Sacramento area since 1986. She had a hospital based Ob/Gyn practice until three years ago, and now performs out-of-hospital births. She has a good understanding of the challenges faced in hospital based practice as well as in the home birth arena. Dr. Adams concluded that she is currently involved with peer review with midwives in the area, and thought she could add something unique to the MAC.

Ms. Lowe asked the MAC for a nomination to recommend one physician and surgeon applicant to the Board, to fill the vacancy.

Ms. Ehrlich nominated Dr. Anne Marie Adams for the physician and surgeon position to be recommended for approval at the next Quarterly Board meeting; s/Ms. Sparrevohn. Motion carried unanimously.

Ms. Marceline thanked Dr. Mendez for attending the MAC meeting and applying for the physician and surgeon vacancy.

Ms. Lowe presented the vacancy for the public member position, a three-year term, set to expire June 30, 2019. The six applications received for the public member vacancy were from: Julia Golden Blackburn, Patricia Bradshaw, Anne Dohn, Jocelyn Dugan, Denise Ellison, and Jennifer Kamel. Ms. Lowe asked if any applicants in attendance would like to address the MAC.

Ms. Dugan introduced herself and stated that she has a personal connection to midwives. Professionally she has been working with midwives across the state for five to six years in various capacities. Most notably, she has served as Treasurer for the California Association of Midwives. Ms. Dugan felt that keeping mothers and babies safe and having good outcomes is of paramount importance. Developing and maintaining a high quality standard of care for midwives across the state is one of the things she considered vital, as well as obtaining outcomes, compiling data, and educating people. Ms. Dugan stated that she would bring a unique prospective as a public member since she is knowledgeable about midwifery.

Ms. Lowe asked the MAC for a nomination to recommend one public applicant to the Board, to fill the vacancy.

Ms. Ehrlich nominated Ms. Jocelyn Dugan for the public member position to be recommended for approval at the next Quarterly Board meeting; s/Ms. Marceline. Motion carried. 3-1 (Opposed: Ms. Sparrevohn)

Agenda Item 10 **Program Update**

A. Licensing Statistics

Ms. Lowe referred to the statistical chart provided in the meeting materials, stating that the Board continues to receive an average amount of applications per quarter.

Ms. Ehrlich referred to the statistics provided at the bottom of the chart reflecting the licensing population, and questioned if there were 361 current licensees as of June 2015.

Ms. Lowe clarified that the chart on the bottom of the page is a snapshot of the total licensing population at the end of each fiscal year.

Ms. Yaroslavsky suggested moving the most recent data to the left side of the chart and everything older to the right side so it would be easier to read.

B. Enforcement Statistics

Ms. Lowe referred to the statistical chart provided in the meeting materials, stating that staff had made minor edits to the Enforcement Statistics report, which included: changing the title “Number of Opened investigations” to “Total Number of Complaints Referred for Investigation,” and added the new field “Total Number of Investigations Currently Open” to capture the number of investigations pending, because staff did not want to infer that the investigative process had not begun for those cases.

Ms. Lowe stated that the Board had received one LM complaint during the quarter and no referrals for disciplinary action. The Board received 29 hospital reporting forms for a total of 62 forms received thus far for the fiscal year.

Ms. Lowe stated that staff felt it was important to provide clarification in regard to the Board’s process for handling the hospital reporting forms. Ms. Lowe stated that B& P section 2510 requires hospitals to report each transfer by a licensed midwife of a planned out-of-hospital birth to the Board and to the California Maternal Quality Care Collaborative. Upon receipt of the form, Board staff review the information provided, and determine what action is required, if any. Ms. Lowe stated that if it appears that additional review is warranted, a complaint is initiated. Ms. Lowe clarified that a complaint initiated does not mean that the Board would initiate an investigation.

Ms. Lowe reminded everyone that the mission of the Board is to protect healthcare consumers and if the Board failed to obtain additional information, or to begin an investigation based on egregious information presented, the Board would not be fulfilling that mission.

Ms. Lowe stated that if the Board were to obtain information on a licensee of another Board or Bureau, as a consumer protection agency, it is the Board’s responsibility to provide the appropriate agency with the information presented. This would allow them the same opportunity to review and take appropriate action if needed.

Ms. Lowe stated that staff had separated the statistics on the reporting forms from the data related to complaints since staff felt that the hospital reporting forms should not be reflected under Enforcement Statistics. Ms. Lowe added that for future meetings staff would present the hospital reporting forms in their own section to help clarify that it is not necessarily an enforcement issue.

Ms. Sparrevohn requested that the statistics for the hospital reporting forms be delineated, to show how many forms were received for licensed midwives, unlicensed midwives, and certified nurse-midwives.

Ms. Lowe confirmed that license and unlicensed types could be reported separately in the future.

Ms. Sparrevohn suggested that if the Board receives a hospital reporting form in error on a certified nurse-midwife, to return the form to the hospital with a notice indicating that reporting is not required for certified nurse-midwives. Ms. Sparrevohn added that if the hospital wanted to file a complaint, Board staff could make known the correct Board to contact rather than forwarding the form as a complaint to the appropriate Board.

Ms. Lowe indicated that the Board's business processes would be changed so that it is clear that the hospital reporting form is not a complaint. Ms. Lowe stated that if staff received information, regardless of the source, it would be the Board's responsibility to review it, triage it, see what additional information is needed, and determine what type of review is required.

Ms. Marceline questioned if it was a nurse-midwife that was reported to the Board on a hospital reporting form and nothing was done wrong by the nurse-midwife, would the Board not send the form to the Nursing Board.

Ms. Lowe indicated that it would be information pertaining to their licensee and the Board would provide it to the proper licensing authority, regardless of what was provided on the form. The other Board does not necessarily have to initiate an investigation, but they have the ability, and they should be reviewing information provided for a licensee of their Board.

Ms. Marceline questioned if any statistical data was being compiled from the reporting form.

Ms. Lowe stated that once regulations were drafted to define what could be requested, the form would be used for additional statistical purposes.

Ms. Marceline questioned who was working on the regulations and whether there was an interested parties meeting scheduled to discuss.

Ms. Lowe indicated that there are not any additional interested parties meetings scheduled at this time.

Ms. Webb stated that the California Hospital Association (CHA) objected to the form that a number of other agencies had reached an agreement on, and then they did not show up to the

interested parties meetings. Therefore, further discussion with the CHA would be required.

Ms. Ehrlich stated that when the law authorized the hospital transfer form to be created and used, it was to be used primarily for information. The form was not for enforcement or for complaints. Ms. Ehrlich stated that she is upset that the form is being used to initiate investigations, and used against a different profession that is not under the authority of the Board. Ms. Ehrlich stated that she recognized the form as being used for consumer protection, but the Board of Registered Nursing is capable of asking for a law to be passed so that it could track its own licensees and is capable of starting its own investigations. Ms. Ehrlich felt that the forms should not be going to the Central Complaint Unit and felt that the form belonged to the executive part of the midwifery program. Ms. Ehrlich added that forms mistakenly sent to the Board should be shredded.

Mr. Worden indicated that how the Board operates and where staff sends information to be reviewed is done within the executive office of the Board. All reporting documents are delivered to the Central Complaint Unit, which is how the Board operates and will continue to operate. Mr. Worden stated that the hospital reporting forms were not intended necessarily to be complaints, and some of the letters would be modified so they are not indicating they are complaints, but would be tracked as an open complaint because the Board needs to track them in the system. Mr. Worden stated that it does not mean a complaint would cause staff to contact the midwife, it does not mean there is a formal investigation; however, if the Central Complaint Unit identifies a problem that is a consumer protection issue, a complaint would be opened, and reviewed, depending to determine whether further action is warranted.

Mr. Worden stated that if the Board receives information from any source that has to do with consumer protection, or another board's or bureau's licensee, all boards and bureaus are required to submit that information to that licensee's official board for consumer protection purposes. How that board chooses to use that form whether to open an investigation or not is at the discretion of that board.

Ms. Marceline questioned if there were instructions for the hospitals on how to complete the form, and if the hospital wanted to make a complaint they should follow the complaint process.

Mr. Worden specified the methods that complaints could be submitted to any of the boards, especially within the Department of Consumer Affairs: people could submit complaints on formal complaint forms, a written piece of paper, or even submitting complaints on the wrong form, as long as staff could identify what it is. Mr. Worden stated that the main mission is consumer protection and the Board will continue to operate in such manner until the form gets developed to a point where staff could collect additional statistics. Mr. Worden added that the way the form is presently drafted; there is very little data that is useful.

Ms. Yaroslavsky asked if the statistics page would be reported differently.

Ms. Lowe confirmed that the statistics would be reported differently.

Ms. Yaroslavsky questioned what was meant by the title “Hospital Reporting Forms Received” on the statistics page.

Ms. Lowe stated that the statistics show how many hospital reporting forms were submitted from a hospital for a licensed midwife, or an unlicensed person, to the Board that were entered into the Board’s database for triage and review.

Ms. Yaroslavsky stated that it was not a method of discipline, or unhappy treatment, or inappropriate behavior, but simply indicated the number of babies that were transferred from home birth to hospital birth.

Ms. Lowe stated that Ms. Yaroslavsky was correct.

Ms. Sparrevohn thought it would be helpful if Mr. Worden indicated what other kinds of forms staff handles in similar nature that comes to the Board that are reviewed the same way.

Mr. Worden stated that physicians and hospitals have mandatory reporting forms that are reviewed by the Central Complaint Unit. Mr. Worden added that not every document turns into a complaint or investigation, but there are some cases that do, which is the same process for the hospital reporting forms.

Ms. Sparrevohn asked how midwives would feel if a reporting form came in on a physician and there was something egregious on it and the Board did nothing. Midwives would not like it. She stated that midwives need to keep it in context and realize the legislature instructed the Board to collect the forms and did not provide specifics on what the Board was supposed to do with the hospital reporting forms. Staff would then have to look at them and decide what to do with them. As Mr. Worden explained, this is the process that exists and no one asked the midwives how they would like it to be, and they did not ask the Board how they would like it to be. It is just the process and the midwives will have to live with what the process is. Ms. Sparrevohn stated that she regrets that it was not clear two years ago on how the forms would be handled. Now that the midwives are clear, it is understood that the forms are directed to the Central Complaint Unit and if a form is received on a licensee of another board, staff has to do something with it. It is not a complaint necessarily, and the word “complaint” will be removed from the document.

Mr. Worden confirmed that the language would be revised.

Ms. Yaroslavsky questioned if the statistics shown for hospital reporting forms means that 62 babies were transferred in quarter one and quarter two.

Ms. Lowe confirmed that the number reflected was the number of reports received from hospitals that received transfers.

Ms. Sparrevohn asked for a timeline for adding more to the form.

Mr. Worden stated that staff had not placed any additional items on the form, because the form the Board tried to put through was objected to by the CHA. The Board could only request information that was outlined in statute, and could not add all of the items that the MAC and ACOG wanted to collect, which is what Ms. Webb had mentioned when speaking of CHA objecting to the revised form. To add additional items would require regulation changes. To move forward, the Board would need to schedule an interested parties meeting, but CHA would need to participate and provide their input. Mr. Worden stated that he would speak with Ms. Kirchmeyer to determine if an interested parties meeting should be scheduled.

Ms. Myrick thanked the Board for making consumer protection a priority, as it is a priority for her as well. Ms. Myrick stated that it is important to understand how the receipt of the hospital reporting form process plays out in the real world. Ms. Myrick provided a personal example indicating that she had a normal straight forward transfer to Marin General Hospital and the hospital incorrectly submitted a hospital reporting form to the Board as a certified nurse-midwife, that is obviously not required, as she is not licensed through the Board. The Board received the form and staff routinely sent the form to the Central Complaint Unit who discovered she was not a licensed midwife. Staff then sent the form to the Board of Registered Nursing who flagged it as a complaint, which is a complicated problem.

Ms. Lowe explained that the form letter that was sent out was a system generated letter, and staff would work on revising the language to make it appropriate for those types of reports.

Ms. Myrick suggested that the form should be returned to the hospital and indicate that the individual incorrectly filed the form to the wrong board.

Ms. Yaroslavsky indicated that staff would review the form letter and revise the language if necessary.

Ms. Sparrevohn suggested that the Board send a letter to alert hospitals that the form exists, that they should be using it for licensed midwives, and what the purpose is.

Ms. Walsh of the California Nurse-Midwives Association (CNMA), stated that she appreciates the clarification received, and referenced a letter that was sent to Ms. Kirchmeyer stating CNMAs concerns regarding the hospital reporting form.

Ms. Bowland commented that she holds licenses as a licensed midwife, a registered nurse, and a certified nurse-midwife. Ms. Bowland stated that she has concerns with the statistics as it states “unlicensed midwives which may include nurse-midwives,” and that is not an accurate description of her profession. Ms. Bowland expressed that it is very serious to send a form that is not a complaint, and is inappropriately filled out on the licensee to another board. Ms. Bowland suggested that a reporting form received for a licensee of another board, should be shredded.

Agenda Item 11 **Agenda Items for the Next Midwifery Advisory Council Meeting in Sacramento**

- Report from the MAC Chair
- Program Update
- Update on AB 1308
- Update on LMAR Task Force
- Update on Midwife Assistant Regulations
- Update on Progress of Crafting Regulations for the Transfer Reporting Form
- Report from CALM regarding the Quality Care Program
- Nomination of the Vacant Licensed Midwife Position
- Approval of the December 3, 2015 and March 10, 2016 MAC Meeting Minutes

Agenda Item 12 **Adjournment**

Ms. Sparrevohn adjourned the meeting at 3:54 p.m.

The full meeting can be viewed at http://www.mbc.ca.gov/About_Us/Meetings/2016/