SB-1237 Nurse-midwives: scope of practice. (2019-2020)

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Senate Bill No. 1237

CHAPTER 88

An act to amend Sections 650.01, 2746.2, 2746.5, 2746.51, and 2746.52 of, and to add Sections 2746.54 and 2746.55 to, the Business and Professions Code, and to amend Sections 102415, 102426, and 102430 of the Health and Safety Code, relating to healing arts.

[Approved by Governor September 18, 2020. Filed with Secretary of State September 18, 2020.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1237, Dodd. Nurse-midwives: scope of practice.

(1) Existing law, the Nursing Practice Act, establishes the Board of Registered Nursing within the Department of Consumer Affairs for the licensure and regulation of the practice of nursing. A violation of the act is a crime. Existing law requires the board to issue a certificate to practice nurse-midwifery to a person who, among other qualifications, meets educational standards established by the board or the equivalent of those educational standards. Existing law authorizes a certified nurse-midwife, under the supervision of a licensed physician and surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother, and immediate care for the newborn. Existing law defines the practice of nurse-midwifery as the furthering or undertaking by a certified person, under the supervision of licensed physician and surgeon who has current practice or training in obstetrics, to assist a woman in childbirth so long as progress meets criteria accepted as normal. Existing law requires all complications to be referred to a physician immediately. Existing law excludes the assisting of childbirth by any artificial, forcible, or mechanical means, and the performance of any version from the definition of the practice of nurse-midwifery.

This bill would delete the above-described provisions defining the practice of nurse-midwifery, would delete the condition that a certified nurse-midwife practice under the supervision of a physician and surgeon, and would instead authorize a certified nurse-midwife to attend cases of low-risk pregnancy, as defined, and childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning services, interconception care, and immediate care of the newborn, consistent with standards adopted by a specified professional organization, or its successor, as approved by the board. The bill would authorize a certified nurse-midwife to practice with a physician and surgeon under mutually agreed-upon policies and protocols that delineate the parameters for consultation, collaboration, referral, and transfer of a patient's care, signed by both the certified nurse-midwife and a physician and surgeon to provide a patient with specified services. The bill, except as specified, would require the patient to be transferred to the care of a physician and surgeon to provide those services if the nurse-midwife does not have those mutually agreed-upon policies and protocols in place, and would authorize the return of that patient to the care of the nurse-midwife after the physician and surgeon has determined that the condition or circumstance that required, or would require, the transfer is resolved. The bill would authorize a certified nurse-midwife to continue to attend the birth of the newborn and participate in physical care, counseling, guidance, teaching, and support, if a physician and surgeon assumes care of the patient, as indicated by the mutually agreed-upon policies and protocols. The bill would authorize a certified nurse-midwife, after referring a patient to a physician and surgeon, to continue care of a patient the patient during a reasonable interval between the referral and the initial

appointment with the physician and surgeon. The bill would authorize a certified nurse-midwife to attend pregnancy and childbirth in an out-of-hospital setting if consistent with the above-described provisions. Under the bill, a certified nurse-midwife would not be authorized to assist childbirth by vacuum or forceps extraction, or to perform any external cephalic version. The bill would require a certified nurse-midwife to refer all emergencies to a physician and surgeon immediately, and would authorize a certified nurse-midwife to provide emergency care until the assistance of a physician and surgeon is obtained.

This bill would require a certified nurse-midwife who is not under the supervision of a physician and surgeon to provide oral and written disclosure to a patient and obtain a patient's written consent, as specified. By expanding the scope of a crime, the bill would impose a state-mandated local program.

(2) Existing law authorizes the board to appoint a committee of qualified physicians and nurses, including, but not limited to, obstetricians and nurse-midwives, to develop the necessary standards relating to educational requirements, ratios of nurse-midwives to supervising physicians, and associated matters. Existing law, additionally, authorizes the committee to include family physicians.

This bill, instead, would require the board to appoint a committee of qualified physicians and surgeons and nurses called the Nurse-Midwifery Advisory Committee. The bill would require the committee to consist of 4 qualified nurse-midwives, 2 qualified physicians and surgeons, including, but not limited to, obstetricians or family physicians, and one public member. The bill would delete the provision including ratios of nurse-midwives to supervising physicians and associated matters in the standards developed by the committee, and would instead require the committee to make recommendations to the board on all matters related to midwifery practice, education, appropriate standard of care, and other matters as specified by the board. The bill would require the committee to provide recommendations or guidance on care when the board is considering disciplinary action against a certified nurse-midwife. The bill would authorize the committee to continue to make the recommendations if the board, despite good faith efforts, is unable to solicit and appoint to the committee 4 qualified nurse-midwives, 2 qualified physicians and surgeons, including, but not limited to, obstetricians or family physicians, and one public member.

(3) Existing law authorizes a certified nurse-midwife to furnish drugs or devices, including controlled substances, in specified circumstances, including if drugs or devices are furnished or ordered incidentally to the provision of care in specified settings, including certain licensed health care facilities, birth centers, and maternity hospitals provided that the furnishing or ordering of drugs or devices occur under physician and surgeon supervision. Existing law requires the drugs or devices to be furnished in accordance with standardized procedures or protocols, and defines standardized procedure to mean a document, including protocols, developed and approved by specified persons, including a facility administrator. Existing law requires Schedule II or III controlled substances furnished or ordered by a certified nurse-midwife to be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician and surgeon. Existing law requires a certified nurse-midwife who is authorized to furnish or issue a drug order for a controlled substance to register with the United States Drug Enforcement Administration.

This bill would delete the condition that the furnishing or ordering of drugs or devices occur under physician and surgeon supervision, and would authorize a certified nurse-midwife to furnish drugs or devices incidentally to the provision of care and services allowed by a certificate to practice nurse-midwifery as provided by the bill and when care is rendered in an out-of-hospital setting, as specified. The bill would limit the requirement that the furnishing or ordering of drugs or devices by a certified nurse-midwife be in accordance with the standardized procedures or protocols to the furnishing or ordering of drugs or devices for services that do not fall within the scope of services specified by the bill and Schedule IV or V controlled substances by a nurse-midwife for any condition. The bill would require Schedule II or III controlled substances furnished or ordered by a certified nurse-midwife for any condition to be furnished or ordered in accordance with a patient-specific protocol approved by a physician and surgeon. The bill would revise the definition of standardized procedure to mean a document, including protocols, developed in collaboration with, and approved by, a physician and surgeon and the certified nurse-midwife. The bill would require a certified nurse-midwife who is authorized to furnish or issue a drug order for a controlled substance to additionally register with the Controlled Substance Utilization Review and Enforcement System (CURES). The bill would authorize a certified nurse-midwife to procure supplies and devices, obtain and administer diagnostic tests, obtain and administer nonscheduled drugs consistent with the provision of services that fall within the scope of services specified by the bill, order laboratory and diagnostic testing, and receive reports, as specified. The bill would make it a misdemeanor for a certified nurse-midwife to refer a person for specified laboratory and diagnostic testing, home infusion therapy, and imaging goods or services if the certified nurse-midwife or their immediate family member has a financial interest with the person receiving a referral. By expanding the scope of a crime, the bill would impose a state-mandated local program.

(4) Existing law authorizes a certified nurse-midwife to perform and repair episiotomies and repair lacerations of the perineum in specified health care facilities only if specified conditions are met, including that the protocols and procedures ensure that all complications are referred to a physician and surgeon immediately, and that immediate care of patients who are in need of care beyond the scope of practice of the certified nurse-midwife, or emergency care for times when the supervising physician and surgeon is not on the premises.

This bill would delete those conditions, and instead would require a certified nurse-midwife performing and repairing lacerations of the perineum to ensure that all complications are referred to a physician and surgeon immediately, and that immediate care of patients who are in need of care beyond the scope of practice of the certified nurse-midwife, or emergency care when a physician and surgeon is not on the premises.

(5) Existing law requires each live birth to be registered with the local registrar of births and deaths for the district in which the birth occurred within 10 days following the date of the event. Existing law makes the professionally licensed midwife in attendance at a live birth that occurs outside of a hospital or outside of a state-licensed alternative birth center responsible for entering the information on the birth certificate, securing the required signatures, and for registering the certificate with the local registrar.

This bill instead would make the professionally licensed midwife or the certified nurse-midwife in attendance responsible for those duties. The bill would additionally require the information collected to include the planned place of birth and whether it was a hospital, freestanding birthing center, home delivery, clinic or physician's office, or other specified place.

(6) Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

(7) Existing law, for live births that occur outside of a hospital or outside of a state-licensed alternative birth center, requires the physician in attendance at the birth or, in the absence of a physician, the professionally licensed nurse-midwife in attendance at the birth or, in the absence of a physician or midwife, either one of the parents to be responsible for entering the information on the certificate of live birth, securing the required signatures, and registering the birth.

This bill would add specified reporting and data collection requirements for certified nurse-midwives to the Nursing Practice Act. The bill, for all maternal or neonatal transfers to the hospital setting during labor or the immediate postpartum period when the place of birth intended at the onset of labor was an out-of-hospital setting with a certified nurse-midwife as birth care provider, would require the certified nurse-midwife to report certain data to the State Department of Public Health within 90 days of the transfer or death, as specified. If a maternal, fetal, or neonatal death occurred in an out-of-hospital setting during labor or the immediate postpartum period, the bill would require the nurse-midwife to report specified data to the department within 90 days of the death, as specified. The bill would require the department to specify the final form of the data submission. By expanding the scope of a crime, the bill would impose a state-mandated local program.

The bill would require, no later than $4^1/_2$ years after these provisions are operative, and annually thereafter, the department to submit a report to the Legislature of the aggregate information, including, but not limited to, birth outcomes of patients under the care of a certified nurse-midwife, collected pursuant to these provisions. The bill would require the department to treat the information and data gathered for the creation of the report to the Legislature as confidential records and prohibit the disclosure of any patient or certified nurse-midwife information to any law enforcement or regulatory agency for any purpose, including, but not limited to, investigations for licensing, certification, or regulatory purposes. The bill would require information collected by the department pursuant to these provisions, not otherwise subject to current confidentiality requirements, to be treated as confidential records and made available only as provided. Under the bill, a violation of these provisions would subject the certified nurse-midwife to disciplinary or administrative action by the Board of Registered Nursing.

This bill would make the operation of the provisions described in paragraph (7) contingent upon appropriation by the Legislature, as specified.

(8) This bill would incorporate additional changes to Section 650.01 of the Business and Professions Code proposed by AB 890 to be operative only if this bill and AB 890 are enacted and this bill is enacted last.

(9) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.
Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

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THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. The Legislature hereby finds and declares the following:

(a) It is the intent of the Legislature to ensure the preservation of nurse-midwifery care in both the hospital and out-of-hospital setting by delineating the scope of practice for certified nurse-midwives.

(b) There is a maternity care workforce crisis in California. At least nine counties have no obstetrician at all, and many more counties fall below the national average for obstetricians. Nurse-midwives and physicians and surgeons can work together to innovatively address this issue and fill gaps in care, before California reaches the point of a critical provider shortage.

(c) California has made great strides in reducing maternal mortality. Nonetheless, there remains a large disparity for Black and indigenous birthing people, and other birthing people of color. The maternal mortality rate for Black women in California is still three to four times higher than White women. Within an integrated model of care, physicians and surgeons and nurse-midwives can work together with patients and community leaders to eradicate this disparity. This measure will set the foundation for that work.

(d) Structural, systemic, and interpersonal racism, and the resulting economic and social inequities and racial disparities in health care are complex problems requiring multiple, innovative strategies in order to turn the tide. Expansion of care teams, working together in a patient-centered approach, is one of these innovative strategies.

(e) State studies show that successful physician-midwifery integration enhances well-being and maternal and neonatal outcomes.

(f) Nurse-midwives attend 50,000 births a year in California and are currently underutilized.

(g) Supporting vaginal birth could improve health outcomes and save millions in annual health care costs in California.

(h) California is the only western state that still requires nurse-midwives to be supervised by a physician and surgeon and one of only four states in the nation that still requires this. Forty-six other states have removed the requirement for physician and surgeon supervision.

(i) Bodily autonomy including the choice of health care provider and the personalized, shared involvement in health care decisions is fundamental to reproductive rights.

(j) Every person is entitled to access dignified, person-centered childbirth and health care, regardless of race, gender, age, class, sexual orientation, gender identity, ability, language proficiency, nationality, immigration status, gender expression, religion, insurance status, or geographic location.

(k) The core philosophy of nurse-midwifery is to provide patient-centered, culturally sensitive, holistic care in collaboration with physicians and surgeons and other health care providers, all of which are key to reducing disparities in maternal health care.

SEC. 2. Section 650.01 of the Business and Professions Code is amended to read:

650.01. (a) Notwithstanding Section 650, or any other provision of law, it is unlawful for a licensee to refer a person for laboratory, diagnostic nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, or diagnostic imaging goods or services if the licensee or their immediate family has a financial interest with the person or in the entity that receives the referral.

(b) For purposes of this section and Section 650.02, the following shall apply:

(1) “Diagnostic imaging” includes, but is not limited to, all X-ray, computed axial tomography, magnetic resonance imaging nuclear medicine, positron emission tomography, mammography, and ultrasound goods and services.

(2) A “financial interest” includes, but is not limited to, any type of ownership interest, debt, loan, lease, compensation, remuneration, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect payment, whether in money or otherwise, between a licensee and a person or entity to whom the licensee refers a person for a good or service specified in subdivision (a). A financial interest also exists if there is an indirect financial relationship between a licensee and the referral recipient including, but not limited to, an arrangement whereby a licensee has an ownership interest in an entity that leases property to the referral recipient. Any financial interest transferred by a licensee to any person or entity or otherwise established in any person or entity for the purpose of avoiding the prohibition of this section shall be deemed a financial interest of the licensee. For purposes of this paragraph, “direct or indirect payment” shall not include a royalty or consulting fee received by a physician and surgeon who has completed a recognized residency training program in orthopedics from a manufacturer or distributor as a result of their research and development of medical devices and techniques for that manufacturer or distributor. For purposes of this paragraph, “consulting fees” means those fees paid by the manufacturer or distributor to a physician and surgeon who has completed a recognized residency training program in orthopedics only for their ongoing services in making refinements to their medical devices or techniques marketed or distributed by the manufacturer or distributor, if the manufacturer or distributor does not own or control the facility to which the physician is referring the patient. A “financial interest” shall not include the receipt of capitation payments or other fixed amounts that are prepaid in exchange for a promise of a licensee to provide specified health care services to specified beneficiaries. A “financial interest” shall not include the receipt of remuneration by a medical director of a hospice, as defined in Section 1746 of the Health and Safety Code, for specified services if the arrangement is set out in writing, and specifies all services to be provided by the medical director, the

term of the arrangement is for at least one year, and the compensation to be paid over the term of the arrangement is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between parties.

(3) For the purposes of this section, “immediate family” includes the spouse and children of the licensee, the parents of the licensee, and the spouses of the children of the licensee.

(4) “Licensee” means a physician as defined in Section 3209.3 of the Labor Code or a certified nurse-midwife as described in Article 2.5 (commencing with Section 2746) of Chapter 6, acting within their scope of practice.

(5) “Licensee’s office” means either of the following:

(A) An office of a licensee in solo practice.

(B) An office in which services or goods are personally provided by the licensee or by employees in that office, or personally by independent contractors in that office, in accordance with other provisions of law. Employees and independent contractors shall be licensed or certified when licensure or certification is required by law.

(6) “Office of a group practice” means an office or offices in which two or more licensees are legally organized as a partnership, professional corporation, or not-for-profit corporation, licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code, for which all of the following apply:

(A) Each licensee who is a member of the group provides substantially the full range of services that the licensee routinely provides, including medical care, consultation, diagnosis, or treatment through the joint use of shared office space, facilities, equipment, and personnel.

(B) Substantially all of the services of the licensees who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group, except in the case of a multispecialty clinic, as defined in subdivision (l) of Section 1206 of the Health and Safety Code, physician services are billed in the name of the multispecialty clinic and amounts so received are treated as receipts of the multispecialty clinic.

(C) The overhead expenses of, and the income from, the practice are distributed in accordance with methods previously determined by members of the group.

(c) It is unlawful for a licensee to enter into an arrangement or scheme, such as a cross-referral arrangement, that the licensee knows, or should know, has a principal purpose of ensuring referrals by the licensee to a particular entity that, if the licensee directly made referrals to that entity, would be in violation of this section.

(d) No claim for payment shall be presented by an entity to any individual, third party payer, or other entity for a good or service furnished pursuant to a referral prohibited under this section.

(e) No insurer, self-insurer, or other payer shall pay a charge or lien for any good or service resulting from a referral in violation of this section.

(f) A licensee who refers a person to, or seeks consultation from, an organization in which the licensee has a financial interest, other than as prohibited by subdivision (a), shall disclose the financial interest to the patient, or the parent or legal guardian of the patient, in writing, at the time of the referral or request for consultation.

(1) If a referral, billing, or other solicitation is between one or more licensees who contract with a multispecialty clinic pursuant to subdivision (l) of Section 1206 of the Health and Safety Code or who conduct their practice as members of the same professional corporation or partnership, and the services are rendered on the same physical premises, or under the same professional corporation or partnership name, the requirements of this subdivision may be met by posting a conspicuous disclosure statement at the registration area or by providing a patient with a written disclosure statement.

(2) If a licensee is under contract with the Department of Corrections or the California Youth Authority, and the patient is an inmate or parolee of either respective department, the requirements of this subdivision shall be satisfied by disclosing financial interests to either the Department of Corrections or the California Youth Authority.

(g) A violation of subdivision (a) shall be a misdemeanor. In the case of a licensee who is a physician and surgeon, the Medical Board of California shall review the facts and circumstances of any conviction pursuant to subdivision (a) and take appropriate disciplinary action if the licensee has committed unprofessional conduct. In the case of a licensee who is a certified nurse-midwife, the Board of Registered Nursing shall review the facts and circumstances of any conviction pursuant to subdivision (a) and take appropriate disciplinary action if the licensee has committed unprofessional conduct. Violations of this section may also be subject to civil penalties of up to five thousand dollars ($5,000) for each offense, which may be enforced by the Insurance

Commissioner, Attorney General, or a district attorney. A violation of subdivision (c), (d), or (e) is a public offense and is punishable upon conviction by a fine not exceeding fifteen thousand dollars ($15,000) for each violation and appropriate disciplinary action, including revocation of professional licensure, by the Medical Board of California, the Board of Registered Nursing, or other appropriate governmental agency.

(h) This section shall not apply to referrals for services that are described in and covered by Sections 139.3 and 139.31 of the Labor Code.

(i) This section shall become operative on January 1, 1995.

SEC. 2.5. Section 650.01 of the Business and Professions Code is amended to read:

650.01. (a) Notwithstanding Section 650, or any other provision of law, it is unlawful for a licensee to refer a person for laboratory, diagnostic nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, or diagnostic imaging goods or services if the licensee or their immediate family has a financial interest with the person or in the entity that receives the referral.

(b) For purposes of this section and Section 650.02, the following shall apply:

(1) “Diagnostic imaging” includes, but is not limited to, all X-ray, computed axial tomography, magnetic resonance imaging nuclear medicine, positron emission tomography, mammography, and ultrasound goods and services.

(2) A “financial interest” includes, but is not limited to, any type of ownership interest, debt, loan, lease, compensation, remuneration, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect payment, whether in money or otherwise, between a licensee and a person or entity to whom the licensee refers a person for a good or service specified in subdivision (a). A financial interest also exists if there is an indirect financial relationship between a licensee and the referral recipient including, but not limited to, an arrangement whereby a licensee has an ownership interest in an entity that leases property to the referral recipient. Any financial interest transferred by a licensee to any person or entity or otherwise established in any person or entity for the purpose of avoiding the prohibition of this section shall be deemed a financial interest of the licensee. For purposes of this paragraph, “direct or indirect payment” shall not include a royalty or consulting fee received by a physician and surgeon who has completed a recognized residency training program in orthopedics from a manufacturer or distributor as a result of their research and development of medical devices and techniques for that manufacturer or distributor. For purposes of this paragraph, “consulting fees” means those fees paid by the manufacturer or distributor to a physician and surgeon who has completed a recognized residency training program in orthopedics only for their ongoing services in making refinements to their medical devices or techniques marketed or distributed by the manufacturer or distributor, if the manufacturer or distributor does not own or control the facility to which the physician is referring the patient. A “financial interest” shall not include the receipt of capitation payments or other fixed amounts that are prepaid in exchange for a promise of a licensee to provide specified health care services to specified beneficiaries. A “financial interest” shall not include the receipt of remuneration by a medical director of a hospice, as defined in Section 1746 of the Health and Safety Code, for specified services if the arrangement is set out in writing, and specifies all services to be provided by the medical director, the term of the arrangement is for at least one year, and the compensation to be paid over the term of the arrangement is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between parties.

(3) For the purposes of this section, “immediate family” includes the spouse and children of the licensee, the parents of the licensee, and the spouses of the children of the licensee.

(4) “Licensee” means all of the following:

(A) A physician as defined in Section 3209.3 of the Labor Code.

(B) A nurse practitioner practicing pursuant to Section 2837.103 or 2837.104.

(C) A certified nurse-midwife as described in Article 2.5 (commencing with Section 2746) of Chapter 6, acting within their scope of practice.

(5) “Licensee’s office” means either of the following:

(A) An office of a licensee in solo practice.

(B) An office in which services or goods are personally provided by the licensee or by employees in that office, or personally by independent contractors in that office, in accordance with other provisions of law. Employees and independent contractors shall be licensed or certified when licensure or certification is required by law.

(6) “Office of a group practice” means an office or offices in which two or more licensees are legally organized as a partnership, professional corporation, or not-for-profit corporation, licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code, for which all of the following apply:

(A) Each licensee who is a member of the group provides substantially the full range of services that the licensee routinely provides, including medical care, consultation, diagnosis, or treatment through the joint use of shared office space, facilities, equipment, and personnel.

(B) Substantially all of the services of the licensees who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group, except in the case of a multispecialty clinic, as defined in subdivision (l) of Section 1206 of the Health and Safety Code, physician services are billed in the name of the multispecialty clinic and amounts so received are treated as receipts of the multispecialty clinic.

(C) The overhead expenses of, and the income from, the practice are distributed in accordance with methods previously determined by members of the group.

(c) It is unlawful for a licensee to enter into an arrangement or scheme, such as a cross-referral arrangement, that the licensee knows, or should know, has a principal purpose of ensuring referrals by the licensee to a particular entity that, if the licensee directly made referrals to that entity, would be in violation of this section.

(d) No claim for payment shall be presented by an entity to any individual, third party payer, or other entity for a good or service furnished pursuant to a referral prohibited under this section.

(e) No insurer, self-insurer, or other payer shall pay a charge or lien for any good or service resulting from a referral in violation of this section.

(f) A licensee who refers a person to, or seeks consultation from, an organization in which the licensee has a financial interest, other than as prohibited by subdivision (a), shall disclose the financial interest to the patient, or the parent or legal guardian of the patient, in writing, at the time of the referral or request for consultation.

(1) If a referral, billing, or other solicitation is between one or more licensees who contract with a multispecialty clinic pursuant to subdivision (l) of Section 1206 of the Health and Safety Code or who conduct their practice as members of the same professional corporation or partnership, and the services are rendered on the same physical premises, or under the same professional corporation or partnership name, the requirements of this subdivision may be met by posting a conspicuous disclosure statement at the registration area or by providing a patient with a written disclosure statement.

(2) If a licensee is under contract with the Department of Corrections or the California Youth Authority, and the patient is an inmate or parolee of either respective department, the requirements of this subdivision shall be satisfied by disclosing financial interests to either the Department of Corrections or the California Youth Authority.

(g) A violation of subdivision (a) shall be a misdemeanor. In the case of a licensee who is a physician and surgeon, the Medical Board of California shall review the facts and circumstances of any conviction pursuant to subdivision (a) and take appropriate disciplinary action if the licensee has committed unprofessional conduct. In the case of a licensee who is a certified nurse-midwife, the Board of Registered Nursing shall review the facts and circumstances of any conviction pursuant to subdivision (a) and take appropriate disciplinary action if the licensee has committed unprofessional conduct. Violations of this section may also be subject to civil penalties of up to five thousand dollars ($5,000) for each offense, which may be enforced by the Insurance Commissioner, Attorney General, or a district attorney. A violation of subdivision (c), (d), or (e) is a public offense and is punishable upon conviction by a fine not exceeding fifteen thousand dollars ($15,000) for each violation and appropriate disciplinary action, including revocation of professional licensure, by the Medical Board of California, the Board of Registered Nursing, or other appropriate governmental agency.

(h) This section shall not apply to referrals for services that are described in and covered by Sections 139.3 and 139.31 of the Labor Code.

(i) This section shall become operative on January 1, 1995.

SEC. 3. Section 2746.2 of the Business and Professions Code is amended to read:

2746.2. (a) An applicant shall show by evidence satisfactory to the board that they have met the educational standards established by the board or have at least the equivalent thereof.

(b) (1) The board shall appoint a committee of qualified physicians and surgeons and nurses called the Nurse-Midwifery Advisory Committee.

(2) The committee shall make recommendations to the board on all matters related to midwifery practice, education, appropriate standard of care, and other matters as specified by the board. The committee shall provide recommendations or guidance on care when the board is considering disciplinary action against a certified nurse-midwife.

(3) The committee shall consist of four qualified nurse-midwives, two qualified physicians and surgeons, including, but not limited to, obstetricians or family physicians, and one public member.

(4) If the board is unable, despite good faith efforts, to solicit and appoint committee members pursuant to the specifications in paragraph (3), the committee may continue to make recommendations pursuant to paragraph (2).

SEC. 4. Section 2746.5 of the Business and Professions Code is amended to read:

2746.5. (a) The certificate to practice nurse-midwifery authorizes the holder to attend cases of low-risk pregnancy and childbirth and to provide prenatal, intrapartum, and postpartum care, including interconception care, family planning care, and immediate care for the newborn, consistent with the Core Competencies for Basic Midwifery Practice adopted by the American College of Nurse-Midwives, or its successor national professional organization, as approved by the board. For purposes of this subdivision, “low-risk pregnancy” means a pregnancy in which all of the following conditions are met:

(1) There is a single fetus.

(2) There is a cephalic presentation at onset of labor.

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

(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 certified nurse-midwife is not qualified to independently address consistent with this section.

(b) (1) The certificate to practice nurse-midwifery authorizes the holder to practice with a physician and surgeon under mutually agreed-upon policies and protocols that delineate the parameters for consultation, collaboration, referral, and transfer of a patient’s care, signed by both the certified nurse-midwife and a physician and surgeon to do either of the following:

(A) Provide a patient with care that falls outside the scope of services specified in subdivision (a).

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

(2) If a physician and surgeon assumes care of the patient, the certified nurse-midwife may continue to attend the birth of the newborn and participate in physical care, counseling, guidance, teaching, and support, as indicated by the mutually agreed-upon policies and protocols signed by both the certified nurse-midwife and a physician and surgeon.

(3) After a certified nurse-midwife refers a patient to a physician and surgeon, the certified nurse-midwife may continue care of the patient during a reasonable interval between the referral and the initial appointment with the physician and surgeon.

(c) (1) If a nurse-midwife does not have in place mutually agreed-upon policies and protocols that delineate the parameters for consultation, collaboration, referral, and transfer of a patient’s care, signed by both the certified nurse-midwife and a physician and surgeon pursuant to paragraph (1) of subdivision (b), the patient shall be transferred to the care of a physician and surgeon to do either or both of the following:

(A) Provide a patient with care that falls outside the scope of services specified in subdivision (a).

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

(2) After the certified nurse-midwife initiates the process of transfer pursuant to paragraph (1), for a patient who otherwise meets the definition of a low-risk pregnancy but no longer meets the criteria specified in paragraph (3) of subdivision (a) because the gestational age of the fetus is greater than 42 weeks and zero days, if there is inadequate time to effect safe transfer to a hospital prior to delivery or transfer may pose a threat to the health and safety of the patient or the unborn child, the certified nurse-midwife may continue care of the patient consistent with the transfer plan described in subdivision (a) of Section 2746.54.

(3) A patient who has been transferred from the care of a certified nurse-midwife to that of a physician and surgeon may return to the care of the certified nurse-midwife after the physician and surgeon has determined that the condition or circumstance that required, or would require, the transfer from the care of the nurse-midwife pursuant to paragraph (1) is resolved.

(d) The certificate to practice nurse-midwifery authorizes the holder to attend pregnancy and childbirth in an out-of-hospital setting if consistent with subdivisions (a), (b), and (c).

(e) This section shall not be interpreted to deny a patient's right to self-determination or informed decisionmaking with regard to choice of provider or birth setting.

(f) The certificate to practice nurse-midwifery does not authorize the holder of the certificate to assist childbirth by vacuum or forceps extraction, or to perform any external cephalic version.

(g) A certified nurse-midwife shall document all consultations, referrals, and transfers in the patient record.

(h) (1) A certified nurse-midwife shall refer all emergencies to a physician and surgeon immediately.

(2) A certified nurse-midwife may provide emergency care until the assistance of a physician and surgeon is obtained.

(i) This chapter does not authorize a nurse-midwife to practice medicine or surgery.

(j) This section shall not be construed to require a physician and surgeon to sign protocols and procedures for a nurse-midwife or to permit any action that violates Section 2052 or 2400.

(k) This section shall not be construed to require a nurse-midwife to have mutually agreed-upon, signed policies and protocols for the provision of services described in subdivision (a).

SEC. 5. Section 2746.51 of the Business and Professions Code is amended to read:

2746.51. (a) Neither this chapter nor any other law shall be construed to prohibit a certified nurse-midwife from furnishing or ordering drugs or devices, including controlled substances classified in Schedule II, III, IV, or V under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code), when all of the following apply:

(1) The drugs or devices are furnished or ordered incidentally to the provision of any of the following:

(A) The care and services described in Section 2746.5.

(B) Care rendered, consistent with the certified nurse-midwife's educational preparation or for which clinical competency has been established and maintained, to persons within a facility specified in subdivision (a), (b), (c), (d), (i), or (j) of Section 1206 of the Health and Safety Code, a clinic as specified in Section 1204 of the Health and Safety Code, a general acute care hospital as defined in subdivision (a) of Section 1250 of the Health and Safety Code, a licensed birth center as defined in Section 1204.3 of the Health and Safety Code, or a special hospital specified as a maternity hospital in subdivision (f) of Section 1250 of the Health and Safety Code.

(C) Care rendered in an out-of-hospital setting pursuant to subdivision (d) of Section 2746.5.

(2) The furnishing or ordering of drugs or devices by a certified nurse-midwife for services that do not fall within the scope of services specified in subdivision (a) of Section 2746.5, and Schedule IV or V controlled substances by a nurse-midwife for any condition, including, but not limited to, Schedule IV or V controlled substances for services that fall within the scope of services specified in subdivision (a) of Section 2746.5, are in accordance with the standardized procedures or protocols. For purposes of this section, standardized procedure means a document, including protocols, developed in collaboration with, and approved by, a physician and surgeon and the certified nurse-midwife. The standardized procedure covering the furnishing or ordering of drugs or devices shall specify all of the following:

(A) Which certified nurse-midwife may furnish or order drugs or devices.

(B) Which drugs or devices may be furnished or ordered and under what circumstances.

(C) The method of periodic review of the certified nurse-midwife's competence, including peer review, and review of the provisions of the standardized procedure.

(3) If Schedule II or III controlled substances, as defined in Sections 11055 and 11056 of the Health and Safety Code, are furnished or ordered by a certified nurse-midwife for any condition, including, but not limited to, Schedule II or III controlled substances for services that fall within the scope of services specified in subdivision (a) of Section 2746.5, the controlled substances shall be furnished or ordered in accordance with a patient-specific protocol approved by a physician and surgeon. For Schedule II controlled substance protocols, the provision for furnishing the Schedule II controlled substance shall address the diagnosis of the illness, injury, or condition for which the Schedule II controlled substance is to be furnished.

(b) (1) The furnishing or ordering of drugs or devices by a certified nurse-midwife is conditional on the issuance by the board of a number to the applicant who has successfully completed the requirements of paragraph (2). The number shall be included on all transmittals of orders for drugs or devices by the certified nurse-midwife. The board shall maintain a list of the certified nurse-midwives that it has certified pursuant to this paragraph and the number it has issued to each one. The board shall make the list available to the California State Board of Pharmacy upon its request. Every certified nurse-midwife who is authorized pursuant to this section to furnish or issue a drug order for a controlled substance shall register with the United States Drug Enforcement Administration and the Controlled Substance Utilization Review and Enforcement System (CURES) pursuant to Section 11165.1 of the Health and Safety Code.

(2) The board has certified in accordance with paragraph (1) that the certified nurse-midwife has satisfactorily completed a course in pharmacology covering the drugs or devices to be furnished or ordered under this section, including the risks of addiction and neonatal abstinence syndrome associated with the use of opioids. The board shall establish the requirements for satisfactory completion of this paragraph.

(3) A copy of the standardized procedure or protocol relating to the furnishing or ordering of controlled substances by a certified nurse-midwife shall be provided upon request to any licensed pharmacist who is uncertain of the authority of the certified nurse-midwife to perform these functions.

(4) Certified nurse-midwives who are certified by the board and hold an active furnishing number, who are currently authorized through standardized procedures or protocols to furnish Schedule II controlled substances, and who are registered with the United States Drug Enforcement Administration shall provide documentation of continuing education specific to the use of Schedule II controlled substances in settings other than a hospital based on standards developed by the board.

(c) Drugs or devices furnished or ordered by a certified nurse-midwife may include Schedule II controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) under the following conditions:

(1) The drugs and devices are furnished or ordered in accordance with requirements referenced in subdivisions (a) and (b).

(2) When Schedule II controlled substances, as defined in Section 11055 of the Health and Safety Code, are furnished or ordered by a certified nurse-midwife, the controlled substances shall be furnished or ordered in accordance with a patient-specific protocol approved by a physician and surgeon.

(d) Furnishing of drugs or devices by a certified nurse-midwife means the act of making a pharmaceutical agent or agents available to the patient. Use of the term “furnishing” in this section shall include the following:

(1) The ordering of a nonscheduled drug or device for services that fall within the scope of services specified in subdivision (a) of Section 2746.5.

(2) The ordering of a nonscheduled drug or device for services that fall outside the scope of services specified in subdivision (a) of Section 2746.5 in accordance with standardized procedures or protocols pursuant to paragraph (2) of subdivision (a).

(3) The ordering of a Schedule IV or V drug for any condition, including, but not limited to, for care that falls within the scope of services specified in subdivision (a) of Section 2746.5, in accordance with standardized procedures or protocols pursuant to paragraph (2) of subdivision (a).

(4) The ordering of a Schedule II or III drug in accordance with a patient-specific protocol approved by a physician and surgeon pursuant to paragraph (3) of subdivision (a).

(5) Transmitting an order of a physician and surgeon.

(e) “Drug order” or “order” for purposes of this section means an order for medication or for a drug or device that is dispensed to or for an ultimate user, issued by a certified nurse-midwife as an individual practitioner, within the meaning of Section 1306.03 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription of the supervising physician; (2) all references to “prescription” in this code and the Health and Safety Code shall include drug orders issued by certified nurse-midwives; and (3) the signature of a certified nurse-midwife on a drug order issued in accordance with this section shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

(f) Notwithstanding any other law, a certified nurse-midwife may directly procure supplies and devices, obtain and administer diagnostic tests, 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, order laboratory and diagnostic testing, and receive reports that are necessary to their practice as a certified nurse-midwife within their scope of practice, consistent with Section 2746.5.

SEC. 6. Section 2746.52 of the Business and Professions Code is amended to read:

2746.52. (a) Notwithstanding Section 2746.5, the certificate to practice nurse-midwifery authorizes the holder to perform and repair episiotomies, and to repair first-degree and second-degree lacerations of the perineum.

(b) A certified nurse-midwife performing and repairing first-degree and second-degree lacerations of the perineum shall do both of the following:

(1) Ensure that all complications are referred to a physician and surgeon immediately.

(2) Ensure immediate care of patients who are in need of care beyond the scope of practice of the certified nurse-midwife, or emergency care for times when a physician and surgeon is not on the premises.

SEC. 7. Section 2746.54 is added to the Business and Professions Code, to read:

2746.54. (a) A certified nurse-midwife shall disclose in 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 certified nurse-midwife and the certified nurse-midwife is not supervised by a physician and surgeon.

(2) The certified nurse-midwife's current licensure status and license number.

(3) The practice settings in which the certified nurse-midwife practices.

(4) If the certified nurse-midwife does not have liability coverage for the practice of midwifery, the certified nurse-midwife shall disclose that fact.

(5) There are conditions that are outside of the scope of practice of a certified nurse-midwife 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 certified nurse-midwife 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 preregistration 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 certified nurse-midwife shall initiate the transfer.

(9) The availability of the text of laws regulating certified nurse-midwifery practices and the procedure for reporting complaints to the Board of Registered Nursing, which may be found on the Board of Registered Nursing'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 certified nurse-midwife shall inform the patient that certified nurse-midwife is independently licensed and practicing midwifery and in that regard is solely responsible for the services the certified nurse-midwife provides.

(b) The disclosure and consent shall be signed by both the certified nurse-midwife and the patient and a copy of the disclosure and consent shall be placed in the patient's medical record.

(c) The Nurse-Midwifery Advisory Committee, in consultation with the board, may recommend to the board the form for the written disclosure and informed consent statement required to be used by a certified nurse-midwife under this section.

(d) This section shall not apply when the intended site of birth is the hospital setting.

SEC. 8. Section 2746.55 is added to the Business and Professions Code, to read:

2746.55. (a) For all maternal or neonatal transfers to the hospital setting during labor or the immediate postpartum period, for which the intended place of birth was an out-of-hospital setting at the onset of labor, or for any maternal, fetal, or neonatal death that occurred in the out-of-hospital setting during labor or the immediate postpartum period, and for which the intended birth care provider is a certified nurse-midwife in the out-of-hospital setting, the department shall collect, and the certified nurse-midwife shall be required to submit, within 90 days of the transfer or death, the following data in the form determined by the department. The data shall include all of the following:

(1) Attendant's name, for the certified nurse-midwife who attended the patient at the time of transfer, or who attended the patient at the time of maternal, fetal, or neonatal death.

(2) Attendant's license number, for the certified nurse-midwife who attended the patient at the time of transfer, or who attended the patient at the time of maternal, fetal, or neonatal death.

(3) The child's date of delivery for births attended by the nurse-midwife.

(4) The sex of the child, for births attended by the nurse-midwife.

(5) The date of birth of the parent giving birth.

(6) The date of birth of the parent not giving birth.

(7) The residence ZIP Code of the parent giving birth.

(8) The residence county of the parent giving birth.

(9) The weight of the parent giving birth (prepregnancy weight and delivery weight of parent giving birth).

(10) The height of the parent giving birth.

(11) The race and ethnicity of the genetic parents, unless the parent declines to disclose.

(12) The obstetric estimate of gestation (completed weeks), at time of transfer.

(13) The total number of prior live births.

(14) The principal source of payment code for delivery.

(15) Any complications and procedures of pregnancy and concurrent illnesses up until time of transfer or death.

(16) Any complications and procedures of labor and delivery up until time of transfer or death.

(17) Any abnormal conditions and clinical procedures related to the newborn up until time of transfer or death.

(18) Fetal presentation at birth, or up until time of transfer.

(19) Whether this pregnancy is a multiple pregnancy (more than one fetus this pregnancy).

(20) Whether the patient has had a previous cesarean section.

(21) If the patient had a previous cesarean, indicate how many.

(22) The intended place of birth at the onset of labor, including, but not limited to, home, freestanding birth center, hospital, clinic, doctor's office, or other location.

(23) Whether there was a maternal death.

(24) Whether there was a fetal death.

(25) Whether there was a neonatal death.

(26) Hospital transfer during the intrapartum or postpartum period, including, who was transferred (mother, infant, or both) and the complications, abnormal conditions, or other indications that resulted in the transfer.

(27) The name of the transfer hospital, or other hospital identification method as required, such as the hospital identification number.

(28) The county of the transfer hospital.

(29) The ZIP Code of the transfer hospital.

(30) The date of the transfer.

(31) Other information as prescribed by the State Department of Public Health.

(b) In the event of a maternal, fetal, or neonatal death that occurred in an out-of-hospital setting during labor or the immediate postpartum period, a certified nurse-midwife shall submit to the department, within 90 days of the death, all of the following data

in addition to the data required in subdivision (a):

(1) The date of the maternal, neonatal, or fetal death.

(2) The place of delivery, for births attended by the nurse-midwife.

(3) The county of the place of delivery, for births attended by the nurse-midwife.

(4) The ZIP Code of the place of delivery, for births attended by the nurse-midwife.

(5) The APGAR scores, for births attended by the nurse-midwife.

(6) The birthweight, for births attended by the nurse-midwife.

(7) The method of delivery, for births attended by the nurse-midwife.

(c) The data submitted pursuant to subdivisions (a) and (b) shall be in addition to the certificate of live birth information required pursuant to Sections 102425 and 102426 of the Health and Safety Code.

(d) For those cases that involve a hospital transfer, the department shall link the data submitted by the certified nurse-midwife, pursuant to subdivision (a), to the live birth data reported by hospitals to the department, pursuant to Sections 102425 and 102426 of the Health and Safety Code, and to the patient discharge data that reflects the birth hospitalization and reported by hospitals to the Office of Statewide Health Planning and Development, so that additional data reflecting the outcome can be incorporated into the aggregated reports submitted pursuant to subdivision (i).

(e) The department may adjust, improve, or expand the data elements required to be reported pursuant to subdivisions (a) and (b) to better coordinate with other data collection and reporting systems, or in order to collect more accurate data, as long as the minimum data elements in subdivisions (a) and (b) are preserved.

(f) The department shall treat the information and data gathered pursuant to this section, for the creation of the reports described in subdivision (i), as confidential records, and shall not permit the disclosure of any patient or certified nurse-midwife information to any law enforcement or regulatory agency for any purpose, including, but not limited to, investigations for licensing, certification, or regulatory purposes. This subdivision shall not prevent the department from responding to inquiries from the Board of Registered Nursing as to whether a licensee has reported pursuant to this section.

(g) The information collected by the department pursuant to this section, and not otherwise subject to current confidentiality requirements, shall be treated as confidential records and shall only be made available for use consistent with paragraph (1) of, paragraph (4) of, and subparagraph (A) of paragraph (8) of, subdivision (a) of Section 102430 of the Health and Safety Code and pursuant to the application, review, and approval process established by the department pursuant to Section 102465 of the Health Safety Code.

(h) At the time of each certified nurse-midwife's license renewal, the Board of Registered Nursing shall send a written notification to the certified nurse-midwife notifying them of the mandated vital records reporting requirements for out-of-hospital births pursuant to subdivisions (a) and (b) and Section 102415 of the Health and Safety Code and that a violation of this section shall subject the certified nurse-midwife to disciplinary or administrative action by the board.

(i) (1) The department shall report to the Legislature on the data collected pursuant to this section. The report shall include the aggregate information, including, but not limited to, birth outcomes of patients under the care of a certified nurse-midwife in an out-of-hospital setting at the onset of labor, collected pursuant to this section and Sections 102425 and 102426 of the Health and Safety Code.

(2) The first report, to reflect a 12-month period of time, shall be submitted no later than four and one-half years after the State Department of Public Health receives an appropriation as specified in subdivison (m) and each subsequent report reflecting a 12-month reporting period shall be submitted annually to the Legislature every year thereafter.

(3) A report required under this subdivision shall be submitted in compliance with Section 9795 of the Government Code.

(j) All reports, including those submitted to the Legislature or made publicly available, shall utilize standard public health reporting practices for accurate dissemination of these data elements, specifically in regards to the reporting of small numbers in a way that does not risk a confidentiality or other disclosure breach. No identifying information in regards to the patient or the nurse-midwife shall be disclosed in the reports submitted pursuant to subdivision (i).

(k) A violation of this section shall subject the certified nurse-midwife to disciplinary or administrative action by the Board of Registered Nursing.

(l) For purposes of this section, “department” means the State Department of Public Health.

(m) This section shall become operative only upon the Legislature making an appropriation to implement the provisions of this section.

SEC. 9. Section 102415 of the Health and Safety Code is amended to read:

102415. For live births that occur outside of a hospital or outside of a state-licensed alternative birth center, as defined in paragraph (4) of subdivision (b) of Section 1204, the physician in attendance at the birth or, in the absence of a physician, the professionally licensed midwife or the certified nurse-midwife in attendance at the birth or, in the absence of a physician or midwife, either one of the parents shall be responsible for entering the information on the certificate, securing the required signatures, and for registering the certificate with the local registrar.

SEC. 10. Section 102426 of the Health and Safety Code is amended to read:

102426. (a) (1) In addition to the items of information collected pursuant to Section 102425, the State Registrar shall instruct all local registrars that have automated birth registration to electronically capture the information specified in paragraph (2), and other necessary items as the State Registrar may designate, in an electronic file. The information shall not be transcribed onto the actual hard copy of the certificate of live birth.

(2) The information required pursuant to paragraph (1) shall consist of the following:

(A) The mother’s marital status.

(B) The mother’s mailing address. The mother may designate an alternate address at her discretion.

(C) Information about whether the birth mother received food for herself during the pregnancy pursuant to the Women, Infants, and Children (WIC) program.

(D) The Activity, Pulse, Grimace, Appearance, and Respiration (Apgar) scores of 5 and 10 minutes.

(E) The birth mother’s prepregnancy weight, weight at delivery, and height.

(F) Information about smoking before and during pregnancy, including the average number of cigarettes or packs of cigarettes smoked during the three months before pregnancy and the average number of cigarettes or packs of cigarettes smoked during each trimester of pregnancy.

(G) The planned place of birth and whether it was a hospital, freestanding birthing center, home delivery, clinic or physician’s office, or other specified place.

(3) Subparagraphs (B) to (F), inclusive, of paragraph (2) shall become operative on January 1, 2007.

(b) Notwithstanding any provision of law to the contrary, information collected pursuant to subparagraph (A) of paragraph (2) of subdivision (a) shall not under any circumstances be disclosed or available to anyone, except for both of the following:

(1) The State Department of Public Health and the Department of Child Support Services for demographic and statistical analysis. The Department of Child Support Services shall keep information received pursuant to this subdivision confidential in accordance with Section 17212 of the Family Code.

(2) The federal government, without any personal identifying information, for demographic and statistical analysis.

SEC. 11. Section 102430 of the Health and Safety Code is amended to read:

102430. (a) The second section of the certificate of live birth as specified in subdivision (b) of Section 102425, the electronic file of birth information collected pursuant to subparagraphs (B) to (F), inclusive, of paragraph (2) of subdivision (a) of Section 102426, the birth mother linkage collected pursuant to Section 102425.2, and the second section of the certificate of fetal death as specified in Section 103025, are confidential. Access to the confidential portion of any certificate of live birth or fetal death, the electronic file of birth information collected pursuant to subparagraphs (B) to (G), inclusive, of paragraph (2) of subdivision (a) of Section 102426, and the birth mother linkage collected pursuant to Section 102425.2 shall be limited to the following:

(1) Department staff.

(2) Local registrar’s staff and local health department staff when approved by the local registrar or local health officer, respectively.

(3) The county coroner.

(4) Persons with a valid scientific interest as determined by the State Registrar, who are engaged in demographic, epidemiological, or other similar studies related to health, and who agree to maintain confidentiality as prescribed by this part and by regulation of the State Registrar.

(5) The parent who signed the certificate or, if no parent signed the certificate, the mother.

(6) The person named on the certificate.

(7) A person who has petitioned to adopt the person named on the certificate of live birth, subject to Section 102705 of the Health and Safety Code and Sections 9200 and 9203 of the Family Code.

(8) The following state government departments requesting the information for official government business purposes as deemed appropriate by the State Registrar, that agree to maintain confidentiality as prescribed by this part:

(A) The State Department of Public Health.

(B) The State Department of Health Care Services.

(C) The Department of Finance. This section shall not be construed as a limitation of the authority granted to the Department of Finance in Sections 13073 to 13073.5, inclusive, of the Government Code.

(D) The Scholarshare Investment Board, for the purpose of implementing the California Kids Investment and Development Savings Program pursuant to Article 19.5 (commencing with Section 69996) of Chapter 2 of Part 42 of Division 5 of Title 3 of the Education Code.

(9) The birth hospital responsible for preparing and submitting a record of the birth or fetal death for purposes of reviewing and correcting birth or fetal death records. The birth hospital shall not further disclose the information nor use the information for purposes other than allowed by this part.

(b) (1) The department shall maintain an accurate record of all persons who are given access to the confidential portion of the certificates. The record shall include all of the following:

(A) The name of the person authorizing access.

(B) The name, title, and organizational affiliation of persons given access.

(C) The dates of access.

(D) The specific purpose for which the information is to be used.

(2) The record of access shall be open to public inspection during normal operating hours of the department.

(c) All research proposed to be conducted using the confidential medical and social information on the birth certificate or fetal death certificate shall first be reviewed by the appropriate committee constituted for the protection of human subjects that is approved by the federal Department of Health and Human Services and has a general assurance pursuant to Part 46 of Title 45 of the Code of Federal Regulations. Information shall not be released until the request for information has been reviewed by the Vital Statistics Advisory Committee and the committee has recommended to the State Registrar that the information shall be released.

SEC. 12. The Legislature finds and declares that Section 8 of this act, which adds Section 2746.55 of the Business and Professions Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

The limitations on the public's right of access imposed by Section 8 are necessary to protect sensitive material from public disclosure.

SEC. 13. Section 2.5 of this bill incorporates amendments to Section 650.01 of the Business and Professions Code proposed by both this bill and AB 890. That section of this bill shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2021, (2) each bill amends Section 650.01 of the Business and Professions Code, and (3) this bill is enacted after AB 890, in which case Section 2 of this bill shall not become operative.

SEC. 14. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or

infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.