HB

71

HOUSE COMMITTEE REPORT

(11)
Date Referred to Committee: February 12, 2003 **FURTHER REFERRALS:**

Date of Committee Action: 2/20/03

The FINANCE Committee considered: **HB 71**

HOUSE BILL NO. 71 **EXTEND BOARD OF MIDWIVES**

"An Act extending the termination date of the Board of Certified Direct-Entry Midwives."

Recommends it be replaced with [ ] HCS *or* [ ] CS *for* _____ (_____)
For Senate Bills with new title: [ ] Technical Title [ ] New Title: HCR_____ **[ ] Same Title [ ] New Title**

[ ] attach amendments
[ ] add new referral to _____Committee
[ ] Letter of Intent_____Committee

List of Abbrev for Depts.:
ADM
CED
COR
CRT
EED
DEC
DFG
GOV
HSS
LEG
LAW
LWF
MVA
DNR
DPS
REV
DOT
UA

NEW **FISCAL NOTES** *Assigned by Chief Clerk's Office				
List by Dept(s):	*FN#	Fiscal	Indet.	Zero

PREVIOUS **FISCAL NOTES**				
List by Dept(s):	FN#	Fiscal	Indet.	Zero
DCED	1	✓		

Signing with recommendations	Printed Last Name	DP	DNP	NR	AM
	Meyer	✓			
	Hawker	✓			
	STOLTZE			✓	
	Toole	✓			
	CROFT	✓			
	MOSES	✓			
	Whitaker	✓			
	FOSTER	X			
Chair					
Chair:	Williams	✓			

FISCAL NOTE

STATE OF ALASKA
2003 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: HB 71
(H) Publish Date: 2/12/03

Revision Date/Time (Note if correction):
Dept. Affected: DCED

Title: An Act extending the termination date of the Board of Certified Direct-Entry Midwives
BRU: Occupational Licensing (117)
Component: Occupational Licensing
Sponsor: House State Affairs
Requester: House Labor & Commerce
Component No.: 2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Personal Services	14.6	14.6	14.6	14.6	14.6	
Travel	5.1	5.1	5.1	5.1	5.1	
Contractual	8.5	8.5	8.5	8.5	8.5	
Supplies	0.0	0.0	0.0	0.0	0.0	
Equipment	0.0	0.0	0.0	0.0	0.0	
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	28.2	28.2	28.2	28.2	28.2	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (1156)	28.2	28.2	28.2	28.2	28.2	

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other 1156- Receipt Supported Services	28.2	28.2	28.2	28.2	28.2	
TOTAL	28.2	28.2	28.2	28.2	28.2	0.0

Estimate of any current year (FY2003) cost: 28.2
Mark this box (X) if funding for this bill is included in the Governor's FY 2004 budget proposal: X

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

The bill extends the Board of Certified Direct-Entry Midwives to June 30, 2007. In accordance with AS 08.03.020, funding is extended one year following the termination date allowing the board to conclude its affairs. The information above identifies direct expenditure and revenue information included in the FY 2004 Operating Budget request. New funds are not required to implement this bill.

Prepared by: Jennifer Strickler, Administrative Manager
Phone (907) 465-2144
Division: Occupational Licensing
Date/Time 2/10/03 12:00 PM
Approved by: Edgar Blatchford, Commissioner
Date 2/10/2003
Agency: Department of Community & Economic Development

(Revised 9/2001 OMB)

COMMITTEE COPY

HOUSE BILL NO. 71

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-THIRD LEGISLATURE - FIRST SESSION

BY THE HOUSE STATE AFFAIRS COMMITTEE

Introduced: 1/31/03
Referred: Labor and Commerce, Finance

A BILL

FOR AN ACT ENTITLED

"An Act extending the termination date of the Board of Certified Direct-Entry Midwives."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 08.03.010(c)(8) is amended to read:

(8) Board of Certified Direct-Entry Midwives (AS 08.65.010) -- June 30, 2007 [2003];

New Text Underlined [DELETED TEXT BRACKETED]

ALASKA STATE LEGISLATURE

Representative Bruce Weyhrauch

HOUSE DISTRICT 4

ALASKA
STATE CAPITOL
JUNEAU, ALASKA
99801-1182

(907) 465-3744
FAX (907) 465-2273

HB 71
Sponsor Statement

Extend The Board of Certified Direct-Entry Midwives

The Board of Certified Direct-Entry Midwives consists of five members appointed by the Governor: one public member, two certified direct-entry midwives (CDMs), one certified nurse midwife, and one physician who is either an obstetrician or who has specialized obstetric training. The duties of the board include examining and certificating applicants, permitting apprentices, holding hearings and ordering disciplinary sanctions. The board also adopts regulations to establish certification and certification renewal requirements.

The board has served as a means to make people practicing midwifery aware of the level of experience and education expected of them. Also, by having a board, the individuals that practice midwifery are held accountable to an established standard of care. Women seeking an alternative to hospital care for normal pregnancy and birth rely on the diligence of the board to enhance both the quality and accessibility of their healthcare. One notable enhancement: the board worked with the State of Alaska to establish Medicaid procedures for CDM services, thereby placing Alaska among eight states which both license their traditional midwives and provide Medicaid reimbursement for their services.

The board is scheduled to terminate on June 30, 2003, and if the legislature does not act this session, the board will have one year to conclude its administrative operations. Based upon recommendations by the Division of Legislative Audit, HB 71 would extend the board's termination date to June 30, 2007.

Released: February 1, 2003
Contact: Rep. Bruce Weyhrauch's office at 907.465.3744

Representative _Bruce_Weyhrauch@legis.state.ak.us
www.akrepublicans.org/weyhrauch/

August 17, 2002

Members of the Legislative Budget
and Audit Committee:

In accordance with the provisions of Title 24 of the Alaska Statutes, the attached report is submitted for your review.

DEPARTMENT OF COMMUNITY
AND ECONOMIC DEVELOPMENT
BOARD OF CERTIFIED
DIRECT-ENTRY MIDWIVES
SUNSET REVIEW

August 15, 2002

Audit Control Number

08-20016-02

This audit was conducted as required by AS 44.66.050 and under the authority of AS 24.20.271(l). Alaska Statute 44.66.050(c) lists criteria to be used to assess the demonstrated public need for a given board, commission, agency, or program subject to the sunset review process. Currently under AS 08.03.010(c)(8), the Board of Certified Direct-Entry Midwives is scheduled to terminate on June 30, 2003. If no legislation is adopted extending this date, the board would be allowed one year in which to conclude its administrative operations.

In our opinion, the termination date for the Board of Certified Direct-Entry Midwives should be extended. The regulation and licensure of certified midwives contributes to the protection of the public's welfare. We recommend the legislature extend the termination date of the Board of Certified Direct-Entry Midwives to June 30, 2007.

This sunset review was conducted in accordance with generally accepted government auditing standards. Fieldwork procedures utilized in the course of developing this report are set out in the Objectives, Scope, and Methodology section.

Pat Davidson, CPA
Legislative Auditor

TABLE OF CONTENTS

	Page
Objectives, Scope, and Methodology	1
Organization and Function	3
Report Conclusions	5
Analysis of Public Need	7
Agency Response:	
Department of Community and Economic Development	13

OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with the intent of Titles 24 and 44 of the Alaska Statutes, we have reviewed the activities of the Board of Certified Direct-Entry Midwives. As required by AS 44.66.050(a), the committees of reference shall consider this report during the legislative oversight process to determine whether the board should be reestablished. Currently, AS 08.03.010(c)(8) requires that the board will terminate on June 30, 2003, and will have one year from that date to conclude its administrative operations.

Objectives

The three central, interrelated objectives of our report are:

1. To determine if the termination date of the board should be extended.

2. To determine if the board is operating in the public interest.

3. To determine if the board has exercised appropriate regulatory oversight of direct-entry midwives.

The assessment of the operations and performance of the board was based on criteria set out in AS 44.66.050(c). Criteria set out in this statute relate to the determination of a demonstrated public need for the board.

Scope and Methodology

Under the direction and supervision of the Division of Legislative Audit, another auditor conducted the majority of this review. We followed professional standards to determine that the other auditor was independent and that their work was competent and sufficient.

The major areas of our review were licensing, examination, and board proceedings. We reviewed and evaluated the following:

1. Applicable statutes and regulations.

2. Compliance with statutes and regulations related to the certification of direct-entry midwives and permits for midwife apprentices.

3. Files and documentation of individuals certified as a direct-entry midwife or permitted to act as a midwife apprentice. Additionally, we reviewed files for individuals applying for certification or an apprentice's permit.

4. Files related to investigations carried out by the Division of Occupational Licensing involving allegations of violations of statutes and regulations related to certified direct-entry midwives or apprentices.

5. Minutes of board meetings and division correspondence files.

6. Annual reports issued by the board.

We also conducted interviews with Division of Occupational Licensing staff.

ORGANIZATION AND FUNCTION

In 1992, the legislature established the Board of Certified Direct-Entry Midwives. The prime sponsor of the legislation that created the board testified before various committees of referral that the intent of the board was to protect the health and safety of the public. The board was to accomplish this by identifying individuals who, practicing as midwives, were willing to pursue technical training and meet specified technical qualifications necessary for formal licensure.

According to the sponsor, insurance companies and state Medicaid would reimburse for midwife services only if the practitioners were properly licensed and certified. He testified that a board is needed to *"develop strict regulations and monitor professional practice by peer review and education. Certified, licensed, high quality care would be available to Alaskans who either prefer home births or are denied financial or geographic access to physicians' care."* The sponsor also identified midwife care as one way to reduce health care costs and related health insurance premiums.

The board promotes the public's health, safety, and welfare by establishing educational, experience, and continuing education requirements for licensed midwives. These requirements are intended to provide assurance that licensed individuals provide a minimum standard of care. State law does allow for midwife services to be provided by unlicensed individuals. As stated in AS 08.65.150, the differentiation is that those not certified under state law *"may not practice midwifery for compensation."*

Membership of the board

Alaska Statute 08.01.020 provides for the following requirements related to appointment to the board:

Board members are appointed by the governor and serve at the pleasure of the governor. Unless otherwise provided, the governor may designate the chair of a board, and all the other officers shall be elected by the board members. Unless otherwise provided, officers of a board are the chair and the secretary. A board may provide by regulation that three or more unexcused absences from meetings are cause for removal.

Board of Certified Direct-Entry Midwives *(As of June 30, 2002)*
Dana Brown, CDM, CPM, Chairperson
Marilyn Holmes, Secretary
Mark E. Richey, MD
Martha Linden, CDM
Sharon K. Evans, CDM

By statute, the board consists of five members. The five members are required to consist of two certified direct-entry midwives, one certified nurse midwife, one physician licensed by the Alaska State Medical Board who has an obstetrical practice or has specialized training in obstetrics, and one public member. Once appointed, the members serve staggered terms of four years.

Duties of the board

The board's responsibilities under AS 08.65.030 include:

1. Examining applicants and issuing certificates to those applicants it finds qualified;
2. Adopting regulations establishing certification and certificate renewal requirements;
3. Issuing permits to apprentice direct-entry midwives;
4. Holding hearings and ordering the disciplinary sanction of a person who violates statute or regulation regarding direct-entry midwives;
5. Supplying forms for applications, licenses, permits, certificates, and other papers and records;
6. Reporting annually to the governor and the Department of Community and Economic Development (DCED) on the board's proceedings during the year;
7. Approving curricula and adopting standards for basic education, training, and apprentice programs; and
8. Approving education, training, and apprentice programs that meet the requirements of statute and the board, and denying, revoking, or suspending approval of programs that fail to meet the requirements.

Department of Community and Economic Development

DCED provides administrative and investigative assistance to the board (AS 08.01.050). Licensing and application fees, as appropriated by the legislature, fund this assistance. Administrative assistance includes budgetary services and functions such as: collecting fees, maintaining files, receiving and issuing application forms, and publishing notice of examinations and meetings.

DCEC is empowered with the authority to act on its own initiative, or in response to a complaint. DCEC may:

1. Conduct an investigation if it appears a person is engaged in, or is about to engage in, a practice over which DCED has authority.
2. Issue an order that the person stop the practice.
3. Bring an action in superior court to enjoin the act.
4. Examine the books and records of an individual.
5. Issue subpoenas for the attendance of witnesses and records.

REPORT CONCLUSIONS

In our opinion, the termination date for the Board of Certified Direct-Entry Midwives should be extended. The regulation and licensing of qualified direct-entry midwives contributes to the protection of the public's health, safety, and welfare. Women seeking to give birth through the use of midwives rely on the diligence of the board and staff to promote the provision of quality midwifery services.

The board serves this public interest by establishing minimum educational and work experience requirements that individuals must meet in order to become a certified direct-entry midwife. The board further serves this public interest by investigating complaints against certified professionals and taking disciplinary action when appropriate. The board has carried out its responsibilities in a manner consistent with statutes, good administrative practice, and the public interest.

The board has served as a means to make people practicing midwifery aware of the level of experience and education expected of them. Also, by having a board, individuals that practice midwifery can now be held accountable to an established standard of care. The board has displayed its ability to conduct its business in a professional, competent, and efficient manner. The board continues to propose changes to statute and regulation to improve its effectiveness.

AS 08.03.010(c)(8) requires the Board of Certified Direct-Entry Midwives be terminated on June 30, 2003. Under AS 08.03.020, the board has one year in which to conclude its administrative operations. Based upon our review of the operations of the Board of Certified Direct-Entry Midwives over the past three fiscal years, we recommend the legislature extend the board's termination date to June 30, 2007.

(Intentionally left blank)

ANALYSIS OF PUBLIC NEED

The following analyses of board activities relate to the public need factors defined in AS 44.66.050. These analyses are not intended to be comprehensive, but address those areas we were able to cover within the scope of our review.

Determine the extent to which the board has operated in the public interest.

The Board of Certified Direct-Entry Midwives (CDM) has served the public interest by examining and licensing qualified applicants, and by proposing changes to statute and regulation in order to enhance the quality of midwifery care in Alaska.

The board developed regulations to establish a peer review committee to review birth summaries and other required medical records to determine if a certified midwife acted in accordance with governing CDM regulations and statutes.

The board developed a four-page handbook for applicants, licensees, new board members, and other interested individuals. After receiving input from the public, the board has decided to revise the handbook, and is currently considering changes and additions.

At the conclusion of the last sunset review, high fees were considered a barrier to entry. The board has pursued various strategies in reducing the necessary fees and has been able to lower the license renewal fee to the current $950.

The board worked with the State of Alaska to establish Medicaid procedures for CDM services, thereby placing Alaska among eight states which both license their traditional midwives and provide Medicaid reimbursement for their services.

After much discussion regarding the licensing of foreign-trained applicants, the board decided that it was in the profession's and the public's best interest to require foreign-trained applicants to meet the established standards when applying for licensure in Alaska.

The board believes it would be in the public's best interest to require licensing of birth centers (currently they are only required to register with the State) and has sought support for such legislation.

Determine the extent to which the operation of the board has been impeded or enhanced by existing statutes, procedures, and practices, which it has adopted, and any other matter, including budgetary, resource, and personnel matters.

Since its inception, a major issue for the board has been the amount of licensing fees charged to license holders. Currently, certified midwives pay a biennial licensing fee of $950. This

amount represents a reduction from $1,550 charged to midwives in the previous two-year licensing period.

These fees result from the language of the general licensing statutes at AS 08.01.065(c), which require *"...that the total amount of fees collected for an occupation approximately equals the actual regulatory costs for the occupation."* Much of the high fees midwives pay can be attributed to high legal costs incurred by the board in developing the first set of professional regulations, and participating in a lawsuit involved with alleged unlicensed practice.

Another factor in the high fees is the relatively small number of certified midwives licensed by the State. As of July 2002, there were 25 licensed midwives and eight apprentices licensed by the State. With this relatively small number of licensees, the board experiences substantial diseconomies of scale in trying to adequately fund effective professional oversight and regulation.

Board members have expressed concern that the high licensing fees have been a disincentive to individuals considering entry into the profession.

We reviewed the internal records maintained by the Division of Occupational Licensing related to revenues and expenditures associated with the Board of Certified Direct-Entry Midwives. We did not audit this information, and present it here for general information purposes. As the schedule on the opposite page reflects, the Board of Certified Direct-Entry Midwives is setting various fees for the occupations it regulates to sufficiently cover the costs of operating the board.

State of Alaska
Board of Certified Direct-Entry Midwives
Schedule of License Revenues and Board Expenditures
FY 98 - FY 01
(Unaudited)

	FY01	FY00	FY99	FY98
Total Revenues:	$ 28,560	$ 11,930	$ 29,505	$ 5,025
Board/Occupation Direct Expenditures:				
Personal Services	$ 9,835	$ 6,659	$ 8,257	$ 6,710
Travel (See Note)	3,946	3,463	310	2,562
Contractual	4,692	2,565	1,433	2,322
Supplies	2	20	73	21
Total Board/Occupation Direct Expenditures	$ 18,475	$ 12,707	$ 10,073	$ 11,615
Total Administrative Indirect Expenditures	1,086	703	839	981
Total Direct and Indirect Expenditures	$ 19,561	$ 13,410	$ 10,912	$ 12,596
Revenues Compared to Expenditures	$ 8,999	$ (1,480)	$ 18,593	$ (7,571)
Cumulative Surplus or (Deficit) for Board Operations	$ 27,441	$ 18,442	$ 19,922	$ 1,329

Note - The $310 total for Travel costs in FY 99 appears to be in error. At the time of our report, the Division of Occupational Licensing was in the process of reviewing their records to determine what adjustment may be necessary to charge costs appropriately.

Determine the extent to which the board has recommended statutory changes that are generally of benefit to the public interest.

The board has primarily focused its administrative efforts on developing regulations to carry out its regulatory responsibilities related to midwifery. Over the past few years, the board has not spent any significant effort developing or supporting proposed legislation.

Determine the extent to which the board has encouraged interested persons to report to it concerning the effect of its regulations and decisions on the effectiveness of services, economy of service, and availability of services that it has provided.

The location, date, and time of board meetings are published in the appropriate prominent publications within the State. The Department of Law defines adequate public notice as advertising at least three days, excluding weekends and holidays, and ten days when possible, prior to a meeting. We reviewed advertising confirmations for the period under review, and the department's policy on public notice requirements, and found the board to be in full compliance with these public notice requirements.

In addition to the required public notices, the board also maintains a web site on the Internet that contains notices of regular board meetings, actions taken by the board, and proposed regulations.

Determine the extent to which the board has encouraged public participation in the making of its regulations and decisions.

Time is available at all public meetings for public testimony. The board also accepts and reviews written comments to be discussed at board meetings. On several occasions, this correspondence was from a member of the public, and involved issues before the board.

Determine the efficiency with which public inquiries or complaints regarding the activities of the board filed with it, with the department to which a board is administratively assigned, or with the Office of the Ombudsman have been processed and resolved.

For the 45 month period from June 1, 1998, through March 31, 2002, the only two cases involving midwives related to the activities of the same license holder. In February 2001, the individual was fined $5,000 by the board when an audit revealed that she had not completed the continuing professional education (CPE) coursework she claimed to have taken. This coursework was necessary for license renewal. The board suspended $4,000 of the fine, reprimanded the licensee, and suspended her license to practice until she came into compliance with the board's CPE requirements.

As a result of an investigation completed in June 2002, the board has summarily suspended the individual's license and reinstated the balance of the fine previously suspended.

There were no complaints filed with the Office of the Ombudsman for the period under review.

Determine the extent to which the board regulates entry into an occupation or profession and whether it has presented qualified applicants to serve the public.

Overall, the application process for certified direct-entry midwife licensure appears reasonable and appropriate. The board has issued twelve new CDM licenses since the last sunset audit. The licensing process is neither unduly restrictive nor too lax, and the board is presenting qualified applicants to serve the public.

The board discussed procedures for licensure of foreign-trained applicants and concluded that it was in the profession's and the public's best interest to require them to fulfill the same requirements as all other applicants.

As of the time of the review, the board had issued a total of 35 CDM licenses (currently 25 active), and 30 CDM-Apprentice permits (currently 7 active). This represents approximately double the number of licensed CDMs at the time of the last sunset audit.

New Certifications Issued	FY 00	FY 01	FY 02	Total	Current Licenses as of June 30, 2002
Midwives	4	4	2	10	25
Apprentices	5	4	2	11	7

Determine the extent to which state personnel practices, including affirmative action requirements, have been complied with by the board to its own activities and the area of activity or interest.

We found no evidence that the board is not complying with state personnel practices, including affirmative action, in qualifying applicants.

Determine the extent to which statutory, regulatory, budgeting or other changes are necessary to enable the board to better serve the interest of the public and to comply with the factors enumerated in AS 44.66.050.

The board believes it is in the profession's and the public's best interest to require all CDM applicants and renewals to pass an exam on state statutes and regulations applicable to the profession. Currently, the board does not have statutory authority to make successful completion of such an examination a condition of licensure. The board has, however, developed a two-hour self-study course that all applicants and renewal applicants are encouraged to complete.

(Intentionally left blank)

Tony Knowles, Governor

Alaska Department of Community and Economic Development

Division of Occupational Licensing
P.O. Box 110806, Juneau, AK 99811-0806
Telephone: (907) 465-2534 • Fax: (907) 465-2974 • Text Telephone: (907) 465-5437
Email: License@dced.state.ak.us • Website: www.dced.state.ak.us/occ/

September 24, 2002

Ms. Pat Davidson
Legislative Auditor
Division of Legislative Audit
Juneau, AK 99811

Dear Ms. Davidson,

Thank you for the opportunity to respond to the preliminary audit of the Board of Certified Direct- Entry Midwives.

The Division of Occupational Licensing agrees with the audit recommendation to extend the board until 2007. The licensing and regulation of midwives contributes significantly to public safety and health options. The board and staff do an excellent job.

Sincerely,

Catherine Reardon, Director

DEPARTMENT OF COMMUNITY AND ECONOMIC DEVELOPMENT
OCCUPATIONAL LICENSING

EXPENDITURE AND REVENUE REPORT FOR THE BOARD OF DIRECT ENTRY MIDWIVES

September 23, 2002

Direct Entry Midwives *(In Thousands)*		FISCAL YEAR 2001	FISCAL YEAR 2002
PERSONAL SERVICES EXPENSES (71000)	Direct	9.8	14.6
	Indirect	0.6	0.6
Total:		$10.4	$15.2
Personal service expenses are employee salaries and benefits. In Fiscal Year 1994 the Division began using detailed time sheets to record actual time spent on the various licensing areas.			
TRAVEL EXPENSES (72000)	Direct	3.9	5.1
	Indirect	0.0	0.0
Total:		$3.9	$5.1
Travel expenses include transportation, food and lodging for board meetings, complaint investigations, disciplinary hearings and national meetings.			
CONTRACTUAL SERVICES EXPENSES (7300(	Direct	4.7	8.5
	Indirect	0.4	0.4
Total:		$5.1	$8.9
Contractual services are services purchased from sources outside the Division and include telephone calls, postage, expert witnesses, Department of Law legal work, and other costs.			
SUPPLIES EXPENSES (74000)	Direct	0.0	0.0
	Indirect	0.0	0.0
Total:		$0.0	$0.0
Supply expenses include paper, envelopes, cassette tapes, and other office supplies.			
EQUIPMENT EXPENSES(75000)	Direct	0.0	0.0
	Indirect	0.1	0.0
Total:		$0.1	$0.0
Equipment expenses include purchase and repair of computers, software, copy machines, telephones and other office equipment.			
Total Direct:		$18.4	$28.2
Total Indirect:		$1.1	$1.0
TOTAL EXPENSES:		$19.5	$29.2
TOTAL REVENUE:		28.6	7.7

JUNEAU
FAMILY BIRTH
CENTER

Juneau Family Birth Center
3225 Hospital Drive, Suite 106, Juneau, AK 99801 (907)586-1203

Midwives Association of Alaska
Kaye Kanne, CDM, President
P.O. Box 22256
Juneau, Ak 99802
907-586-1203

Representative Bruce Weyrauch
State Capitol, Room 427
Juneau, Ak 99801

January 29, 2003

Dear Representative Weyrauch,

Thank you for introducing HB 71, a bill to extend the Certified Direct-Entry Licensing Board. I had the privilege of sitting on the Board from its inception in 1992 through 1999. The Board has done an exemplary job of writing and implementing regulations for the governing of Certified Direct-Entry midwives in Alaska. The Board continues to strive for the highest standards for CDM's and as a result, midwives in Alaska are professional, well trained and provide safe, excellent care for women and families.

Alaska has one of the best midwifery laws in the United States. Many other states have looked to us as an example when passing midwifery legislation. Direct-Entry midwifery is increasingly recognized across the nation, with licensing for direct-entry midwives in 21 states, and legislation pending in 8 more states. Many more women are seeking the continuity of care and family centered maternity care which midwifery can provide.

The American Public Health Association endorses state regulated and national certified Direct-Entry midwives to improve outcomes while lowering healthcare costs for maternity care. They support efforts to increase access to out-of-hospital maternity care services, through recognition that Direct-Entry midwives can serve clients desiring, safe, planned out-of-hospital midwifery care.

Alaska is at the forefront of Direct-Entry midwifery licensing. Let's continue the excellent work we have been doing by continuing the Certified Direct-Entry licensing Board for another 4 years.

Sincerely,

Kaye Kanne

Kaye Kanne, CDM, President
Midwives Association of Alaska

FISCAL NOTE

STATE OF ALASKA
2003 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB 71
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: DCED

Title: An Act extending the termination date of the Board of Certified Direct-Entry Midwives
BRU: Occupational Licensing (117)
Component: Occupational Licensing
Sponsor: House State Affairs
Requester: House Labor & Commerce
Component No.: 2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Personal Services	14.6	14.6	14.6	14.6	14.6	
Travel	5.1	5.1	5.1	5.1	5.1	
Contractual	8.5	8.5	8.5	8.5	8.5	
Supplies	0.0	0.0	0.0	0.0	0.0	
Equipment	0.0	0.0	0.0	0.0	0.0	
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**28.2**	**28.2**	**28.2**	**28.2**	**28.2**	**0.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (1156)	**28.2**	**28.2**	**28.2**	**28.2**	**28.2**	

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other 1156- Receipt Supported Services	28.2	28.2	28.2	28.2	28.2	
TOTAL	**28.2**	**28.2**	**28.2**	**28.2**	**28.2**	**0.0**

Estimate of any current year (FY2003) cost: 28.2
Mark this box (X) if funding for this bill is included in the Governor's FY 2004 budget proposal: X

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

The bill extends the Board of Certified Direct-Entry Midwives to June 30, 2007. In accordance with AS 08.03.020, funding is extended one year following the termination date allowing the board to conclude its affairs. The information above identifies direct expenditure and revenue information included in the FY 2004 Operating Budget request. New funds are not required to implement this bill.

Prepared by: Jennifer Strickler, Administrative Manager
Phone (907) 465-2144
Division: Occupational Licensing
Date/Time 2/10/03 12:00 PM
Approved by: Edgar Blatchford, Commissioner
Date 2/10/2003
Agency: Department of Community & Economic Development

JUNEAU
FAMILY BIRTH
CENTER

Juneau Family Birth Center
3225 Hospital Drive, Suite 106, Juneau, AK 99801 (907)586-1203

Midwives Association of Alaska
Kaye Kanne, CDM, President
C/O
Juneau Family Birth Center
Juneau, Ak 99802
907-586-1203

Honorable Representative William Williams
State Capitol, Room 511
Juneau, Ak 99801

February 17, 2003

Dear Representative Williams,

Thank you for supporting HB 71, a bill to extend the Certified Direct-Entry Licensing Board. I had the privilege of sitting on the Board from its inception in 1992 through 1999. The Board has done an exemplary job of writing and implementing regulations for the governing of Certified Direct-Entry midwives in Alaska. The Board continues to strive for the highest standards for CDM's and as a result, midwives in Alaska are professional, well trained and provide safe, excellent care for women and families.

Alaska has one of the best midwifery laws in the United States. Many other states have looked to us as an example when passing midwifery legislation. Direct-Entry midwifery is increasingly recognized across the nation, with licensing for direct-entry midwives in 21 states, and legislation pending in 8 more states. Many more women are seeking the continuity of care and family centered maternity care which midwifery can provide.

The American Public Health Association endorses state regulated and national certified Direct-Entry midwives to improve outcomes while lowering healthcare costs for maternity care. They support efforts to increase access to out-of-hospital maternity care services, through recognition that Direct-Entry midwives can serve clients desiring, safe, planned out-of-hospital midwifery care.

Alaska is at the forefront of Direct-Entry midwifery licensing. Let's continue the excellent work we have been doing by continuing the Certified Direct-Entry licensing Board for another 4 years.

Sincerely,

Kaye Kanne

Kaye Kanne, CDM, President
Midwives Association of Alaska

Citizens for Midwifery
Supporting the Midwives Model of Care
www.cfmidwifery.org . 888-236-4880

Fact Sheet

Safety in Birth Begins With
Midwifery Care

"In terms of quality, satisfaction, and costs, the midwifery model for pregnancy and maternity care has been found to be beneficial to women and families, resulting in good outcomes and cost savings. ... With its focus on pregnancy as a normal life event and health promotion for women of all ages, the midwifery model of care is an appropriate alternative or complement to the medical approach to childbirth."

American Public Health Association, "Supporting Access to Midwifery Services in the United States (Position Paper)", *American Journal of Public Health*, Vol. 91, No. 3, March 2001.

"It is inherently unwise, and perhaps unsafe, for women with normal pregnancies to be cared for obstetric specialist ... Midwives and general practitioners, on the other hand, are primarily oriented to the care of women with normal pregnancies, and are likely to have more detailed knowledge of individual women."

Murray Enkin, et al, *A Guide to Effective Care in Pregnancy and Childbirth*. Oxford University Press, 2000.

"It is the finding and vision of the Taskforce that the midwifery model of care is an essential element of comprehensive health care for women and their families that should be embraced by, and incorporated into, the health care system and made available to all women."

Dower CM, Miller JE, O'Neil EH and the Taskforce on Midwifery, *Charting a Course for the 21st Century: The Future of Midwifery*. San Francisco, CA: Pew Health Professions Commission and the UCSF Center for the Health Professions. April 1999.

"Midwives are the most appropriate primary health care provider to be assigned to the care of normal birth."

Maternal and Newborn Health/Safe Motherhood Unit of the World Health Organization, *Care in Normal Birth: A practical guide*. World Health Organization, 1996.

"Midwives attend the vast majority of births in those industrialized countries with the best perinatal outcomes..."

Coalition for Improving Maternity Services, *The Mother-Friendly Childbirth Initiative*, 1996

Citizens for Midwifery

Supporting the Midwives Model of Care
www.cfmidwifery.org . 888-236-4880

Fact Sheet

The Safety of Home Birth

The evidence is overwhelming – planned home birth is safe for healthy women

"Recognizing the evidence that births to healthy mothers, who are not considered at medical risk after comprehensive screening by trained professionals, can occur safely in various settings, including out-of-hospital birth centers and homes ...Therefore, APHA Supports efforts to increase access to out-of-hospital maternity care services..."

American Public Health Association, "Increasing Access to Out-of-Hospital Maternity Care Services through State-Regulated and Nationally-Certified Direct-Entry Midwives (Policy Statement)". *American Journal of Public Health*, Vol 92, No. 3, March 2002.

"Several methodologically sound observational studies have compared the outcomes of planned home-births (irrespective of the eventual place of birth) with planned hospital-births for women with similar characteristics. A meta-analysis of these studies showed no maternal mortality, and no statistically significant differences in perinatal mortality risk in either direction."

Murray Enkin, et al, *A Guide to Effective Care in Pregnancy and Childbirth*. Oxford University Press, 2000.

"It is safe to say that a woman should give birth in a place where feels is safe, and at the most peripheral level at which appropriate care is feasible an safe. For a low-risk pregnant woman this can be at home, at a small maternity clinic or birth centre, in town or perhaps at the maternity unit of a larger hospital. However, it must be a place where all the attention and care are focused on her needs a safety, as close to home and her own culture as possible.

Maternal and Newborn Health/Safe Motherhood Unit of the World Health Organization, *Care in Normal Birth: A practical guide*. World Health Organization, 1996.

"Excellent outcomes with much lower intervention rates are achieved at home births. This may be because the overuse of interventions in hospital births introduces risks or the home environment promotes problem-free labors."

Henci Goer, Obstetric Myths versus Research Realities: A Guide to the Medical Literature. Bergin & Garvey, 1995.

"This study supports previous research indicating that planned home birth with qualified care providers can be a safe alternative for healthy lower risk women."

Anderson RE, Murphy PA. "Outcomes Of 11,788 Planned Home Births Attended By Certified Nurse-Midwives. A Retrospective Descriptive Study." *Journal of Nurse Midwifery*, 1995 Nov-Dec;40(6):483-92. (Abst)

"Increasing Access To Out-Of-Hospital Maternity Care Services Through State-Regulated and Nationally-Certified Direct-Entry Midwives"

Formally adopted by the Governing Council of the American Public Health Association (APHA)
Wednesday, October 24, 2001

THE AMERICAN PUBLIC HEALTH ASSOCIATION,

Reaffirming its position on credentials for health occupations, that there should be alternative routes involving educational systems of selection and preparation, and legal systems of licensing by which people can prepare and qualify for health occupations (1)

Reaffirming its recognition that many women seek birthing alternatives(2) and,

Recognizing that pregnancy and birth are normal life events for a majority of women, (3,4,5) and,

Reaffirming its endorsement of the philosophy of family-centered maternity care, the importance of continuity of care, and the use of a variety of licensed care-givers, (6)

Recognizing that Direct-entry Midwives encompass a diverse group of midwives that have entered the profession directly through midwifery education and training, and not through a pre-requisite program such as nursing.(7)
Recognizing that there are alternative educational systems of selection and preparation for national certification of Direct entry Midwives that include either the Certified Professional Midwife (CPM) credential and the Certified Midwife (CM) credential; and that both require didactic programs, written examinations and clinical experience. (8,9) In the case of the Certified Professional Midwives the didactic component consists of education in a program accredited by an agency that is recognized by the US Department of Education or the PEP Program, the North American Registry of Midwives competency based, educational portfolio evaluation, and the clinical component is equivalent to one year of experience which includes more than a thousand contact hours under the supervision of one or more preceptors, some of which must be in out-of-hospital settings, but none of which need to be in hospital settings;(8) and in the case of the Certified Midwife (CM) credential requires education in institutions of higher learning accredited by an agency that is recognized by the US Department of Education to meet the same standards that Certified Nurse Midwives must meet, completing core science requirements similar to those required for a nurse, and fulfilling core midwifery requirements that are a part of all accredited nurse-midwifery education programs, and clinical experience that must include hospital experience, but is not required to include out-of-hospital experience.(9)

Recognizing that individual states interested in incorporating direct-entry midwives into their health care systems are moving towards regulatory models based on national certification.(5)

Recognizing evidence that many women seek alternatives to hospital care for normal pregnancy and birth, and,

Recognizing the evidence that births to healthy mothers, who are not considered at medical risk after comprehensive screening by trained professionals, can occur safely in various settings, including out-of-hospital birth centers and homes (10,11,12,13,14) and,

Noting that an epidemiological study of Certified Professional Midwives (CPMs) is ongoing in order to further substantiate practice outcomes, safety, client satisfaction, and practitioner competency is in progress; (15)

Recognizing that out-of-hospital settings have the potential for reducing the costs of maternity care; (7,12,16)

Recognizing evidence that access to quality maternity caregivers remains an important issue, particularly for underserved urban and rural communities;(17) which may be addressed through out-of-hospital maternity services in some communities; and

Reaffirming that the APHA currently recognizes the value of and promotes educational opportunities for nurse-midwifery,(18) and that many professionals recognize the contributions of direct-entry midwifery; and,

Reaffirming that APHA has been an innovator in public health care by supporting research on alternative and complementary medicine (1,19) and increased access to midwifery services in the United States, (20)

Recognizing that there should be alternative routes involving educational systems of selection and preparation, and legal systems of licensing by which people can prepare and qualify for health occupations, including those direct-entry midwives who are nationally-certified and who have successfully completed "a recognized midwifery education process"; (21,22,23,25) and

Recognizing evidence that direct-entry midwives have multiple educational routes (22,24) available to them in order to meet the entry-level requirements of knowledge, skills and experience; (22,24,25)

Recognizing evidence that individual states interested in incorporating direct-entry midwives into the health care system are moving towards regulatory models based on national certifications; (22)

Therefore, APHA

- Supports efforts to increase access to out-of-hospital maternity care services and increase the range of quality maternity care choices available to consumers, through recognition that legally-regulated and nationally certified direct-entry midwives can serve clients desiring safe, planned, out-of-hospital maternity care services, and further:
- Encourages the development and implementation of guidelines for the licensing, certification and practice for direct-entry midwifery practitioners for use by state and local health agencies, health planners, maternity care providers, and professional organizations;
- Urges that there be increased opportunities, for supervised, clinical learning experiences, in a variety of settings, including both high-risk and low-risk, incorporated into direct-entry midwifery education programs;
- Encourages an increase in cost effective maternal care services for rural and underserved urban populations by advocating for increases in funding of scholarships and loan repayment programs targeted at members of these communities;
- Urges public and private insurance plans to eliminate barriers to the reimbursement and equitable payment of direct-entry midwifery services in both public and private payment systems;
- Encourages the National Center for Health Statistics, the U.S. Department of Health and Human Services and State Vital Records Offices to add the CPM as a separate certifier category on birth certificates to enable routine collection of systematic data;
- Urges HRSA, CDC and state health departments to improve the collection and quality of vital statistics and other data to enhance the monitoring of birth outcomes (e.g., infant and perinatal mortality rates, maternal mortality rates, etc.) resulting from services provided by all practitioners including specific types of midwife practitioners;
- Urges Congress and appropriate Department of Health and Human Services agencies to increase funding and other support for ongoing research and evaluation of maternal health and birth outcomes, practice outcomes, quality of care outcomes, and safety related to the services provided by direct-entry midwives;

References:

1. American Public Health Association Policy Statement 6805: Credentials for Health Occupations. APHA Public Policy Statements, 1948 to present, cumulative. Washington, D.C. current volume.
2. American Public Health Association Position Paper 8209: Guidelines for Licensing and Regulating Birth Centers. APHA Public Policy Statements, 1948 to present, cumulative. Washington, D.C. current volume.
3. Stewart, David: The Five Standards of Safe Childbearing, NAPSAC International, 4th Edition, 1997.
4. Care in Normal Birth: a practical guide, Technical Working Group, World Health Organization. Department of Reproductive Health and Research, Section 1 1-1.6, 1999.
5. Rooks, JR: Midwifery and Childbirth in America. Temple University Press, Philadelphia, 1997.
6. American Public Health Association Position Paper 7924: Alternatives in Maternity Care APHA Public Policy Statements, 1948 to present, cumulative. Washington, D.C. current volume.
7. Rooks, JP. Unity in Midwifery? Realities and Alternatives. Journal of Nurse-Midwifery 1998; 43:315-19.
8. North American Registry of Midwives (NARM), How to Become a Certified Professional Midwife and Candidate Information Bulletin. Revised, June, 2000
9. ACNM Issue Brief February 1999 and ACNM Position Statement on Midwifery Education 1997

10. Durand AM: The safety of home birth: The Farm study. Am J Public Health 1992;82:450-453
11. MacDorman M, SinghG: Midwifery care, social and medical risk factors and birth outcomes in the USA. J. Epidemiol Community Health 1998, 52: 310-317.
12. Wagner M: Midwifery in the Industrialized world. Journal of the Society of Obstetricians and Gynaecologists of Canada, November 1998.
13. Mehl, LE, Ramiel, JR, Leininger, B., Hoff, B, Kroenthal, K. Peterson, G: Evaluation of Outcomes of non-nurse midwives: Matched comparison with physicians. Women & Health 1980;5:17-29
14. Sullivan D & Weitz: Labor Pains: Modern Midwives and Homebirth, Yale University Press, 1988.
15. Ken Johnson, PhD and Betty Ann Daviss, MA. CPM Statistics Project 2000: A prospective study of births by Certified Professional Midwives in North America. (Abstract #3042.0) Presented at 128th APHA Annual Meeting, Boston, MA, November 2000.
16. Blevins Medical Monopoly: Protecting Consumers or Limiting Competition? Policy Analysis by Cato Institute December 15, 1995; 246: 11-14. Burnette CA, Jones JA, SA:
17. Tennessee Commission on Children and Youth Report: The State of the Child in Tennessee: KIDS COUNT, 1996.
18. American Public Health Association Position Paper 9403: Increase Support for Education and Practice Opportunities for Nurse-Midwives, 1948 to Present, Cumulative, Washington, D.C.: American Public Health Association; current volume.
19. American Public Health Association Position Paper 9714: Support for Research on Alternative and Complementary Practices, 1948 to Present, Cumulative, Washington, D.C.: American Public Health Association; current volume.
20. American Public Health Association Position Paper 20004: Supporting Access to Midwifery Services in the United States, 1948 to Present, Cumulative, Washington, D.C.: American Public Health Association; current volume.
21. Charting A Course for the 21st Century: The Future of Midwifery. A Joint Report of the PEW Health Commission and the University of California, San Francisco Center for the Health Professions, April 1999.
22. Myers-Ciecko J: Evolution and Current Status of Direct-Entry Midwifery Education, Regulation, And Practice in the United States, with Examples from Washington State. The Journal of Nurse-Midwifery, Vol. 44, No. 4, July/Aug. 1999, pp 384-392.
23. Midwifery Today. Paths To Becoming a Midwife: Getting an Education, Midwifery Today, Inc. 1998.
24. Haughton P, Windom KL: 1995 Job Analysis of the Role of Direct-Entry Midwives. June 1996.
25. Mahlman R. The Quality of the NARM Certification Process, Testimony before the Ohio Study Council on Midwifery, Associate Director of Assessment Services, Vocational Instructional Materials Laboratory, The Ohio State University, July 1997

Resolution Submitted by:

Sharon Wells, MS, LM, CPM
Carol Nelson, LM, CPM
Jonathan B. Kotch, MD, MPH
Stanley H. Weiss, MD, FACP
James Gaudino, MD, MS, MPH

Citizens for Midwifery

Supporting the Midwives Model of Care
www.cfmidwifery.org . 888-236-4880

Fact Sheet

Overview of Maternity Care in the US

Carolyn Keefe, MLS

With four million births each year[1] and three-quarters of American women becoming mothers, maternity care affects large numbers of women. It is also big business. The United States has the highest per capita spending on health care in the world, with maternity care ranking sixth overall,[2] and childbirth is the most common reason for the hospitalization of women in the United States.

Women are subjected to an ever-increasing array of interventions and technologies, many of which are highly invasive, with little or no evidence of their effectiveness. In fact, the medical evidence shows that the routine use of unnecessary interventions put mothers and babies at risk. Medical interventions are also expensive and often used not for the benefit of women and babies, but for the convenience or legal protection of doctors and hospitals.

All of this would be acceptable if we had better outcomes to show for it. Unfortunately, our outcomes are not nearly as good as those of developed countries that rely more heavily on midwifery care. Some of the clear problems with our maternity care system include:

- A high infant mortality rate compared to other developed countries – 27th in the world [3] Infant mortality rates are higher for African American, Latina and Native American babies – with the rate for African American babies twice that of white babies.[4]
- A maternal mortality rate that has not improved in 20 years – 15th in the world.[5] Maternal mortality is higher for women of color than for white women, nearly four times higher for African American women.[6]
- A cesarean birth rate of 24.4% – among the highest in the world. Cesarean birth rates are highest for African American women, followed by white women. Latina women, Asian women, and Native American women.[7]
- A 20% drop in vaginal births after cesarean (VBAC) from 2000 to 2001 to 16.4% – access to VBAC is disappearing requiring many women who have cesarean scars to undergo surgery.[8]
- An induction rate of 20.5% – which has more than doubled since 1989 and continues to rise.[9]
- Many mothers traumatized by their treatment during birth, with as many as 30% exhibiting some signs of post-traumatic stress disorder[10] and 50% experiencing some aspect of postpartum depression (the highest such rate in the world).[11]

Moreover:

- Of the eight most common surgical procedures in the US, four are obstetric in nature – episiotomy, repair of obstetric laceration, cesarean birth, artificial rupture of membranes. These are in also the top four surgeries performed on women in the US.[12]
- Obstetric procedures are the most common type of surgical procedures performed in the US (6,174,000), slightly higher than cardiac procedures (6,133,000). Consider the following:
  - obstetric procedures are only performed on women – more obstetric procedures are performed on women than the next two categories (cardiac and digestive) combined;
  - there are over six million obstetric procedures, but just over four million births;
  - these procedures are primarily performed on healthy bodies during a normal physiological process.

Fact Sheet

The problem has steadily gotten worse over the last two decades. All obstetric procedures combined nearly doubled between 1980 and 1999, while certain procedures, such as medical induction of labor, vacuum extraction, and manually assisted delivery increased eleven-fold in that time.[13] Each procedure carries with it risks to mothers and babies, and less invasive techniques exist for most of them. Furthermore, they are usually not medically necessary and are avoidable for the majority of women.

The Midwives Model of Care[14] and the evidence-based Mother-Friendly Childbirth Initiative[15] recognize birth as a normal, natural process and support the use of less invasive techniques, such as position changes, waiting, hydrotherapy, and perineal support, that carry fewer risks to mothers and babies and are usually more effective.

Research shows that midwives are the safest birth attendants for most women, with lower infant and maternal mortality rates and fewer invasive interventions such as episiotomies and surgical births (cesareans). In developed countries where midwives are the primary care providers for pregnant women, mortality and surgical birth rates are much lower than in the United States. However, legal, regulatory, and financial barriers to the practicing the Midwives Model of Care and Mother-Friendly care make it difficult for women to access either in the US.

References:

[1] Martin, Joyce, et al, "Births Final Data for 2001," *National Vital Statistics Reports*, Vol 51, No. 5, December 18, 2002, p. 1
[2] 1999 National Statistics, HCUPnet, Healthcare Cost and Utilization Project. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/data/hcup/hcupnet.htm.
[3]*Child Health USA 2001*, Maternal Child Health Bureau, Health Resources and Services Administration, US Department of Health and Human Services, p. 22.
[4]Hoyert, DL; et al, "Deaths: Final Data for 1999," *National Vital Statistics Report*, Vol. 49, No. 8, September 21, 2001, p. 11.
[5] *State of the World's Mothers 2002*, Save the Children, http://www.savethechildren.org/mothers/sowm02/report/complete_index.pdf.
[6]Hoyert, DL; et al, "Deaths: Final Data for 1999," *National Vital Statistics Report*, Vol. 49, No. 8, September 21, 2001, p. 89.
[7]Martin, Joyce, et al, "Births Final Data for 2001," *National Vital Statistics Reports*, Vol 51, No. 5, December 18, 2002, p. 16
[8]Martin, Joyce, et al, "Births Final Data for 2001," *National Vital Statistics Reports*, Vol 51, No. 5, December 18, 2002, p. 16
[9]Martin, Joyce, et al, "Births Final Data for 2001," *National Vital Statistics Reports*, Vol 51, No. 5, December 18, 2002, p. 15
[10] Creedy DK, Shochet IM, Horsfall J. "Childbirth and the development of acute trauma symptoms: incidence and contributing factors." *Birth*, 2000 Jun; 27(2):104-11
[11] Wolf, Naomi, *Misconceptions: Truth, Lies, and the Unexpected on the Journey to Motherhood*. Doubleday, 2001, p. 216.
[12] Popovic JR. "1999 National Hospital Discharge Survey: Annual Summary with detailed diagnosis and procedure data," *Vital Health Statistics* 13(51). 2001, p. 35.
[13] IBID, p. 46.
[14]Developed in 1996 by Midwifery Task Force, www.midwiferytaskforce.org.
[15]Developed in 1996 by the Coalition for Improving Maternity Services, www.mother-friendly.org.

• Reflects 2001 data.

AMERICAN PUBLIC HEALTH ASSOCIATION

Increasing Access to Out-of-Hospital Maternity Care Services through State-Regulated and Nationally-Certified Direct-Entry Midwives

01/01/2001
20013

THE AMERICAN PUBLIC HEALTH ASSOCIATION,
Reaffirming its position on credentials for health occupations, that there should be alternative routes involving educational systems of selection and preparation, and legal systems of licensing by which people can prepare and qualify for health occupations1; and
Reaffirming its recognition that many women seek birthing alternatives2; and
Recognizing that pregnancy and birth are normal life events for a majority of women3,4,5; and
Reaffirming its endorsement of the philosophy of family-centered maternity care, the importance of continuity of care, and the use of a variety of licensed care-givers6; and
Recognizing that Direct-entry Midwives encompass a diverse group of midwives that have entered the profession directly through midwifery education and training, and not through a prerequisite program such as nursing7; and
Recognizing that there are alternative educational systems of selection and preparation for national certification of Direct-entry Midwives that include either the Certified Professional Midwife (CPM) credential and the Certified Midwife (CM) credential; and that both require didactic programs, written examinations and clinical experience.8,9 In the case of the Certified Professional Midwives the didactic component consists of education in a program accredited by an agency that is recognized by the US Department of Education or the Portfolio Evaluation Process program, the North American Registry of Midwives competency-based, educational portfolio evaluation, and the clinical component is equivalent to one year of experience which includes more than a thousand contact hours under the supervision of one or more preceptors, some of which must be in out-of-hospital settings, but none of which need to be in hospital settings8; and in the case of the CM credential requires education in institutions of higher learning accredited by an agency that is recognized by the US Department of Education to meet the same standards that Certified Nurse Midwives must meet, completing core science requirements similar to those required for a nurse, and fulfilling core midwifery requirements that are a part of all accredited nurse-midwifery education programs, and clinical experience that must include hospital experience, but is not required to include out-of-hospital experience.9
Recognizing that individual states interested in incorporating direct-entry midwives into their health care systems are moving toward regulatory models based on national certification5; and
Recognizing evidence that many women seek alternatives to hospital care for normal pregnancy and birth, and
Recognizing the evidence that births to healthy mothers, who are not considered at medical risk after comprehensive screening by trained professionals, can occur safely in various settings, including out-of-hospital birth centers and homes10-14; and
Noting that an epidemiological study of Certified Professional Midwives (CPMs) is ongoing in order to investigate and evaluate practice outcomes, safety, client satisfaction, and practitioner competency15; and
Recognizing that out-of-hospital settings have the potential for reducing the costs of maternity care7,12,16; and
Recognizing evidence that access to quality maternity caregivers remains an important issue, particularly for underserved urban and rural communities17; which may be addressed through out-of-hospital maternity services in some communities; and
Reaffirming that the APHA currently recognizes the value of and promotes educational

opportunities for nurse-midwifery,18 and that many professionals recognize the contributions of direct-entry midwifery; and
Reaffirming that APHA has been an innovator in public health care by supporting research on alternative and complementary medicine1,19 and increased access to midwifery services in the United States,20
Recognizing that there should be alternative routes involving educational systems of selection and preparation, and legal systems of licensing by which people can prepare and qualify for health occupations, including those direct-entry midwives who are nationally-certified and who have successfully completed "a recognized midwifery education process"21-23,25; and
Recognizing evidence that direct-entry midwives have multiple educational routes22,24 available to them in order to meet the entry-level requirements of knowledge, skills and experience22,24,25;
Recognizing evidence that individual states interested in incorporating direct-entry midwives into the health care system are moving toward regulatory models based on national certifications22;
Therefore, APHA
1. Supports efforts to increase access to out-of-hospital maternity care services and increase the range of quality maternity care choices available to consumers, through recognition that legally-regulated and nationally certified direct-entry midwives can serve clients desiring safe, planned, out-of-hospital maternity care services, and further:
2. Encourages the development and implementation of guidelines for the licensing, certification and practice for direct-entry midwifery practitioners for use by state and local health agencies, health planners, maternity care providers, and professional organizations;
3. Urges that there be increased opportunities for supervised clinical learning experiences, in a variety of settings, including both high-risk and low-risk, incorporated into direct-entry midwifery education programs;
4. Encourages an increase in cost effective maternal care services for rural and underserved urban populations by advocating for increases in funding of scholarships and loan repayment programs targeted at members of these communities;
5. Urges public and private insurance plans to eliminate barriers to the reimbursement and equitable payment of direct-entry midwifery services in both public and private payment systems;
6. Encourages the National Center for Health Statistics, the US Department of Health and Human Services and State Vital Records Offices to add the CPM as a separate certifier category on birth certificates to enable routine collection of systematic data;
7. Urges HRSA, CDC and state health departments to improve the collection and quality of vital statistics and other data to enhance the monitoring of birth outcomes (e.g., infant and perinatal mortality rates, maternal mortality rates, etc.) resulting from services provided by all practitioners including specific types of midwife practitioners;
8. Urges Congress and appropriate Department of Health and Human Services agencies to increase funding and other support for ongoing research and evaluation of maternal health and birth outcomes, practice outcomes, quality of care outcomes, and safety related to the services provided by direct-entry midwives.
References
1. American Public Health Association Policy Statement 6805: Creden–tials for Health Occupations. APHA Public Policy Statements, 1948 to present, cumulative. Washington, D.C. current volume.
2. American Public Health Association Position Paper 8209: Guidelines for Licensing and regulating Birth Centers. APHA Public Policy Statements, 1948 to present, cumulative. Washington, D.C. current volume.
3. Stewart, David: The Five Standards of Safe Childbearing, NAPSAC International, 4th Edition, 1997.
4. Care in Normal Birth: a practical guide, Technical Working Group, World Health Organization. Department of Reproductive Health and Research, Section 1.1-1.6, 1999.
5. Rooks, JR: Midwifery and Childbirth in America. Temple University Press, Philadelphia, 1997.
6. American Public Health Association Position Paper 7924: Alternatives in Maternity Care. APHA Public Policy Statements, 1948 to present, cumulative. Washington, D.C. current volume.

7. Rooks JP. Unity in Midwifery? Realities and Alternatives. J Nurse-Midwifery 1998;43:315-319.
8. North American Registry of Midwives (NARM), How to Become a Certified Professional Midwife and Candidate Information Bulletin. Revised, June 2000.
9. ACNM Issue Brief February 1999 and ACNM Position Statement on Midwifery Education 1997.
10. Durand AM. The safety of home birth: The Farm Study. Am J Public Health 1992;82:450-453.
11. MacDorman M, Singh G: Midwifery care, social and medical risk factors and birth outcomes in the USA. J Epidemiol Community Health. 1998;52:310-317.
12. Wagner M. Midwifery in the industrialized world. J Soc Obstet Gyn Canada. November 1998.
13. Mehl LE, Ramiel JR, Leininger B, Hoff B, Kroenthal K, Peterson G. Evaluation of outcomes of non-nurse midwives: matched comparison with physicians. Women & Health 1980;5:17-29.
14. Sullivan D, Weitz : Labor Pains: modern midwives and homebirth. Yale University Press, 1988.
15. Ken Johnson, PhD, and Betty Ann Daviss, MA. CPM Statistics Project 2000: A prospective study of births by certified professional midwives in North America. (Abstract #3042.0) Presented at 128th APHA Annual Meeting, Boston, MA, November 2000.
16. Blevins Medical Monopoly: Protecting Consumers or Limiting Competition? Policy Analysis by Cato Institute December 15, 1995;246:11-14. Burnette CA, Jones JA, SA.
17. Tennessee Commission on Children and Youth Report: The State of the Child in Tennessee: KIDS COUNT, 1996.
18. American Public Health Association Position Paper 9403: Increase support for education and practice opportunities for nurse-midwives. APHA Public Policy Statements, 1948 to present, cumulative. Washington, D.C. current volume.
19. American Public Health Association Position Paper 9714: Support for Research on Alternative and Complementary Practices. APHA Public Policy Statements, 1948 to present, cumulative. Washington, D.C. current volume.
20. American Public Health Association Position Paper 20004: Supporting Access to Midwifery Services in the United States. APHA Public Policy Statements, 1948 to present, cumulative. Washington, D.C. current volume.
21. Charting a course for the 21st century: The future of Midwifery. A joint report of the PEW Health Commission and the University of California, San Francisco Center for the Health Professions, April 1999.
22. Myers-Ciecko J. Evolution and current status of direct-entry midwifery education, regulation, and practice in the United States, with examples from Washington State. J Nurse-Midwifery, 1999(Jul-Aug);44(4):384-392.
23. Midwifery Today. Paths to becoming a midwife: Getting an Education, Midwifery Today, Inc. 1998.
24. Haughton P, Windom KL. 1995 Job Analysis of the role of direct-entry midwives. June 1996.
25 Mahlman R. The Quality of the NARM Certification process, testimony before the Ohio Study Council on Midwifery, Associate Director of Assessment Services, Vocational Instructional Materials Laboratory, The Ohio State University, July 1997.

Additional Info.

http://www.apha.org/legislative/policy/policysearch/index.cfm?fuseaction=year

New Search | Back to APHA Home Page

800 I Street N.W., Washington, DC 20001-3710 Phone: (202) 777-APHA Fax: (202) 777-2534 E-mail: comments@apha.org

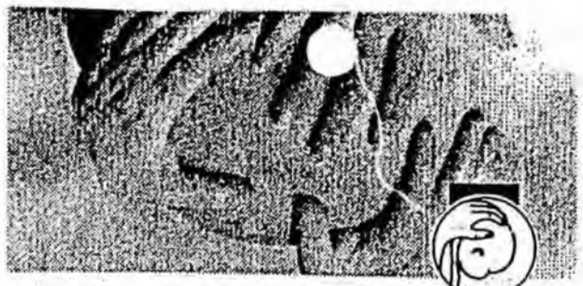
THE
FOLLOWING
DOCUMENT(S)
ARE
POOR
ORIGINAL
COPIES

The five nations with the world's lowest infant mortality rates have midwives attending 70% of all births without a physician in the birth room.

These nations also have the lowest rates of technological intervention including c-sections.

Contact your midwife at:

For more information or to request a free midwifery information kit call toll free at:
1-888-290-1091



Midwives Association of Alaska (MAA)

2650 Broadview Ave.
Wasilla, AK 99654

For a Free Information Kit
Call Toll Free: 1-888-290-1091

CDM MEANS "CERTIFIED DIRECT-ENTRY MIDWIFE"

TRUST
YOUR
BODY
&
YOUR
BABY

Choose
Midwifery
for a Safe

Is My

Why Alaskan Families Choose Midwifery

- Midwifery's excellent safety record
- Reclaiming birth as a natural process
- Continuity of woman centered care
- Father and sibling involvement and potential for family bonding
- Ability to give birth in a safe, familiar, comforting place
- Avoiding drugs which may affect one's baby in the birth process
- Confidence that labor and delivery plans will be honored
- Exposure to research linking natural birth experiences with psychological health
- Midwifery's low statistics for interventions, especially c-sections
- Realizing the potential to tap one's own instincts and avoid interference in the normal birth process
- Recommendation by friends & family
- Water birth options
- Considerable cost savings

What is a CDM?

Certified Direct-Entry Midwives (CDMs) are licensed experts in natural childbirth who monitor the physical, psychological and social well-being of the mother throughout the childbearing cycle.

Midwifery: Questions & Answers

Q: Are Alaska's CDMs licensed?

A: Yes. CDM's are licensed by a state regulatory board which sets standards for their education, apprenticeship, examination, and ongoing review. The Board of Direct-Entry Midwives consists of two CDMs, one nurse mid-wife, one MD with an obstetrical practice and one public member.

Q: What exactly does a CDM offer to expecting mothers?

A: Individualized education and counseling, pre-natal care, continuous hands-on assistance during labor and delivery, post -partum support, and help with

Q: What are the benefits of delivering your baby with a CDM at home or in a midwifery birth center?

A: This experience maximizes the potential for the physical and psychological health of the mother and the newborn, supports maternal and family bonding and establishes a successful breast-feeding experience.

Q: What does the word 'midwife' mean?

A: Midwife means "with woman". CDM's work in partnership with childbearing women, helping them claim the responsibility for decision making with regard to themselves and their

help women avoid th
use of routine obstetri
interventions such as
labor induction, IV's,
anesthetics and
episiotomies.

Q: How can using a midwife result in a considerable cost savings?

A: CDM services are among the most affordable professiona services available for Alaska's childbearing families and are cove by medical insurance Because cesarean sec rates are extremely lo with Alaskan CDMs a the mothers and babi are so healthy, there a many long-term savir as well for this model maternity care.

Midwives Model of Care

What to Expect

from a caregiver who provides the Midwives Model of Care:

Respectful Care

Gentle, nurturing care that respects you, your family and your beliefs.

- Respect for your informed decisions about medical tests, recommendations, interventions.
- Willingness to support your birth plan, including all family members and friends you may want present at the birth.
- Freedom to move, eat, bathe, to do what feels right for you during labor and birth. Your midwife doesn't "manage" or "allow," but patiently supports and guides you as nature does.
- Respect for the birth process as it unfolds uniquely each time. Although amazing, being pregnant and giving birth are actually normal life processes for which a woman's body is well-designed. Each woman's experience is unique.
- Respectful care regardless of setting, although at present this kind of care is most readily found in homes and birth centers.

Personal Attention

- Prenatal visits that allow plenty of time for questions and answers – 30 to 60 minutes for each prenatal appointment is common.
- Meaningful discussions to explore and help resolve fears and concerns you or your family may have.
- Caring attention to develop a trusting and nurturing relationship with you and your family that can help you to labor and give birth naturally and safely.

Plenty of Information

- Plenty of information about pregnancy, birth and the newborn, and about breastfeeding and newborn care.
- Suggestions about ways you can take good care of yourself and your baby.
- Encouragement and practical suggestions for you to have good nutrition and make healthy lifestyle choices.
- Full information about any recommended tests, procedures or treatments so you can make informed choices about your care.

Appropriate Monitoring

- Regular and thorough check-ups for you and your baby throughout your pregnancy, during labor, and after the birth, to make sure both of you are healthy and doing well.
- Recommendations for diagnostic technology when appropriate.
- Planning with you for the unexpected and for the rare emergency.
- Referrals to other health care specialists or to a different birth setting if needed.
- Expertise in normal, natural childbirth. Because they are experts in normal pregnancy and birth, midwives are experienced in the variations of normal birth and recognize the early signs of conditions that are not "normal," including medical conditions or complications that may occasionally arise during pregnancy or the birth process.

Confidence in Your Body

- Help with discovering your own body's ability to give birth, in its own way and in its own time.
- No routine treatments or arbitrary timetables that can interfere with your body's healthy process of laboring and giving birth.
- Truly individualized care, privacy and natural childbirth.
- Support for doing the work of giving birth. Rather than someone else "delivering" the baby, you are empowered to give birth to your own baby yourself!

Natural Techniques for Comfort

- Help you cope with the discomfort of labor. Midwives have found that encouragement, massage, relaxation, laboring in water, changing positions, and other approaches are often very effective.
- Encourage the progress of labor and help you give birth to your baby gently and lovingly.
- Help you avoid risks (to yourself and to your baby) that are associated with many standard medical techniques and hospital protocols.

A Care Provider Who Stays With You

- Attentive, sensitive care and emotional support in tune with your needs throughout labor. Research has shown that having a "sympathetic female companion" with you all through labor and delivery reduces the chance of complications and the likelihood of an unnecessary cesarean section. The Midwives Model of Care means that your midwife stays with you and "mothers the mother."
- Post-partum care and help with breastfeeding. After your baby is born, the midwife will stay with you until breast-feeding is established and both you and your baby are resting comfortably. She will arrange a visit after the birth to check you and your baby and to answer any questions.

Will you receive the Midwives Model of Care from your midwife or doctor? Use this information to ask detailed questions when choosing your caregiver and deciding where you want to give birth. It's also a good idea to question others who have used the caregiver. At present, this degree of individualized and supportive care is most typically provided by midwives in homes and birth centers. Someday, this kind of care will be available in all settings.

Midwives Model of Care

The Midwives Model of Care is based on the fact that pregnancy and birth are normal life processes.

The Midwives Model of Care includes:

- monitoring the physical, psychological and social well-being of the mother throughout the childbearing cycle;
- providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support;
- minimizing technological interventions; and
- identifying and referring women who require obstetrical attention.

The application of this woman-centered model of care has been proven to reduce the incidence of birth injury, trauma and cesarean section.

Midwives Model of Care

Personal,

Practical and

Professional

Citizens *for* Midwifery

Learn, Connect and Take Action

The goal of Citizens for Midwifery is to see that the Midwives Model of Care is available to all childbearing women and universally recognized as the best kind of care for pregnancy and birth. Citizens for Midwifery also endorses the Mother-Friendly Childbirth Initiative.

Citizens for Midwifery
1-888-236-4880
PO Box 82227
Athens, GA 30608
www.cfmidwifery.org

Midwives Model of Care
www.midwivesmodelofcare.org

Congratulations!

You are about to experience the birth of your baby!

Women in the United States are learning that pregnancy and childbirth are normal, healthy processes, not diseases. They are finding out that they and their families can benefit from the care of a midwife.

The Midwives Model of Care includes prenatal visits and "hands-on" care throughout labor, birth and right after. It results in less chance of complications, fewer interventions, and a healthier birth for you and for your baby.

Women are discovering that the hospital is not the only option for safe birth. Women are most likely to labor best in a place where they feel free, safe and private, with attendants whom they know and trust.

Many women find that they feel most comfortable at home or in a birth center, with the ongoing attention and nurturing care of a midwife or doctor trained in gentle, natural, safe childbirth – someone who is an expert in normal birth and provides the Midwives Model of Care.

Pregnancy and childbirth involve every part of you. Feelings, hopes, fears, physical and practical needs, and spiritual or religious beliefs can all affect your pregnancy and birth. A midwife providing the Midwives Model of Care addresses all of these aspects to help you give birth naturally, safely and confidently. In addition, women who experience this type of care report feelings of great satisfaction and empowerment.

Compared to standard medical management, the Midwives Model of Care is a fundamentally different approach to pregnancy and childbirth.

This pamphlet explains what to expect with the Midwives Model of Care, and how this kind of care can help make your childbirth experience a joyous life event.