

HB

26

<TARGET><BILL>HB 26</BILL><SUBJECT>HB
26</SUBJECT><COMM>SFIN29</COMM></TARGET>

SENATE FINANCE COMMITTEE REPORT

DATE: 4/15/15

FURTHER:

DATE TURNED
IN TO OFFICE: _____

Finance Committee considered HOUSE BILL NO. 26

HB 26-EXTEND CERT. DIRECT-ENTRY MIDWIVES BOARD

"An Act extending the termination date of the Board of Certified Direct-Entry Midwives; and providing for an effective date."

and recommends:

- be replaced with SCS _____ (_____) Same Title Technical Title Change New Title/SCR No. _____
- adopt previous SCS CS HB 24 (LHC) Same Title Technical Title Change New Title/SCR No. _____
- attached amendment(s)
- adopt _____ Letter of Intent
- further referral to _____ Committee

Dept Abbr.	
ADM	LWF
CED	LAW
COR	LEG
EED	MVA
DEC	DNR
DFG	DPS
GOV	REV
DHS	DOT
AJS	UA

NEW FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #
CED	✓			

PREVIOUS FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #

APPROPRIATION - no fiscal note

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	MICCICHE			✓	
	BISHOP			✓	
	DUNLEAVY			✓	
	O'SULLIVAN			✓	
	HOFFMAN	✓			
CO-CHAIR:	Kelly	✓			
CO-CHAIR: Anna Mackinnon	Mackinnon	✓			

ALASKA STATE LEGISLATURE

REPRESENTATIVE KURT OLSON

- Chair: Labor and Commerce
- Vice Chair: Rules
- Member: Resources, Legislative Budget & Audit

Session: January - April
State Capitol, Room 24
Juneau, AK 99801-1182
Phone: 907-465-2693
Fax: 907-465-3835



Interim: May - December
145 Main Street Loop, Ste. 221
Kenai, AK 99611
Phone: 907-283-2690
Fax: 907-283-2763

Official Business

Sponsor Statement

HB 26

"An Act extending the termination date of the Board of Certified Direct-Entry Midwives; and providing for an effective date."

HB 26 extends the sunset date for the Board of Certified Direct-Entry Midwives to June 30, 2017.

I encourage all the members to review the Legislative Audit summary and the full audit report. You will see that in the opinion of our auditors, the Board of Certified Direct-Entry Midwives is serving the public's interest by effectively licensing certified direct-entry midwives (CDM) and apprentices. Additionally, it was found that the board worked to improve the profession by modifying and adopting midwifery regulations to conform to current standards of care.

The Board of Certified Direct-Entry Midwives serves an important role in protecting the well-being of Alaskans by identifying individuals who are willing to pursue technical training and meet specified technical qualifications necessary for license as midwives. The continuation of this board is very important to the health and safety of Alaska's women and children.

Thank you for your support of this legislation.

Fiscal Note

State of Alaska
2015 Legislative Session

Bill Version: HB 26
Fiscal Note Number: _____
() Publish Date: _____

Identifier: HB026-DCCED-CBPL-02-06-15
Title: EXTEND CERT. DIRECT-ENTRY MIDWIVES
BOARD
Sponsor: OLSON
Requester: (S) Finance

Department: Department of Commerce, Community and
Economic Development
Appropriation: Corporations, Business and Professional
Licensing
Allocation: Corporations, Business and Professional
Licensing
OMB Component Number: 2360

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2016	Included in	Out-Year Cost Estimates				
	Appropriation Requested	Governor's FY2016 Request	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
OPERATING EXPENDITURES	FY 2016	FY 2016					
Personal Services							
Travel		5.0	5.0				
Services		0.5	0.5				
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	0.0	5.5	5.5	0.0	0.0	0.0	0.0

Fund Source (Operating Only)

1156 Rcpt Svcs		5.5	5.5				
Total	0.0	5.5	5.5	0.0	0.0	0.0	0.0

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues							
---------------------------	--	--	--	--	--	--	--

Estimated SUPPLEMENTAL (FY2015) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2016) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No
If yes, by what date are the regulations to be adopted, amended or repealed?

Why this fiscal note differs from previous version:

Updated to reflect the board sunset in 2017.

Prepared By:	Janey Hovenden, Director	Phone:	(907)465-2538
Division:	Corporations, Business, and Professional Licensing	Date:	04/16/2015 07:25 PM
Approved By:	Catherine Reardon, Director	Date:	04/16/15
Agency:	Division of Administrative Services		

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2015 LEGISLATIVE SESSION

BILL NO. HB026

Analysis

HB26 implements Legislative Audit's recommendation to extend the Board of Certified Direct-Entry Midwives (BCDEM) through June 30, 2017.

This bill extends statutory authorization for the existing BCDEM. Adoption of the bill will continue existing activities by the board and administration by the division. Failure to adopt the bill will result in a one-year wind-down of the board in FY2018, and the division will assume all licensing responsibility in FY2019.

Extension of the BCDEM will require travel for board members and one staff to attend two board meetings per year \$5.0. Service costs include advertising of board meetings \$0.5. These estimated costs are based on the average board specific direct charges to this program over the previous biennium licensing cycle.

If the BCDEM is not extended, the Certified Direct-Entry Midwives licensing program will continue under the direction of the division, rather than the board. Costs associated with licensing the profession will continue to be incurred by the division, including license examiners, investigations, legal, supplies, and allocated administrative support services.

If the board dissolves, but the licensing program remains, the following expenses will still be incurred:

Personal services: \$37.3 (Licensing and investigations staff)

Services: \$4.0 (Includes activities such as legal advice, support from the Office of Administrative Hearings, and postage)

Administrative support: \$10.7 (Includes leased space, information technology support, insurance, risk management, ADA compliance, and other statewide centralized services.)



THE STATE
of **ALASKA**
GOVERNOR BILL WALKER


Department of Commerce, Community,
and Economic Development

DIVISION OF CORPORATIONS, BUSINESS AND
PROFESSIONAL LICENSING

P.O. Box 110806
Juneau, Alaska 99811-0806
Main: 907.465.2550
Fax: 907.465.2974

TO: Hon. Anna Fairclough
Chair, Senate Finance Committee

DATE: 4/16/15

FROM: Sara Chambers 
Professional Licensing Operations Manager

SUBJECT: HB 26 follow-up

As requested by the Senate Finance Committee during its hearing on HB 26, Extend Cert. Direct-Entry Midwives Board, on April 15, 2015, the following information is provided:

Is the term "apprentice," as used by the Board of Certified Direct-Entry Midwives, recognized by the U. S. Department of Labor (USDOL)? (Sen. Bishop)

Apprentice midwives are not part of the USDOL's Registered Apprentice program. The licensed profession is regulated by the board as defined in AS 08.65.090. Neither direct-entry midwives nor their apprentices are included in the USDOL's Standard Occupational Classification System.

Are any direct-entry midwives located in Western Alaska? (Sen. Olson)

Currently licensed midwives and their apprentices are geographically distributed as shown below:

ANCHORAGE, AK	11
DELTA JUNCTION, AK	1
EAGLE RIVER, AK	2
FAIRBANKS, AK	7
HOMER, AK	3
JUNEAU, AK	7
PALMER, AK	7
SANDY, UT	1
SOLDOTNA, AK	1
WASILLA, AK	10

Board member Deborah Schneider testified that the board has been told they are not able to pursue action on licensees if they believe a swift remedy is needed to protect the public.

State law provides for summary suspension of a license "if the board finds that the licensee poses a clear and immediate danger to the public health and safety" (AS 08.01.087(b)) or if the department is aware that "a person has engaged in or is about to engage in an act or practice in violation of a provision of this chapter or a regulation adopted under it..." (AS 08.01.075(c)).

Please contact either Director Janey Hovenden (465-2536) or myself if you have any questions.

HB 26 “Extend Board of Certified Direct-Entry Midwives” Testifiers

Kris Curtis, Legislative Audit

Sara Chambers, Department of Commerce, Community & Economic Development

Director Janey Hovenden, Division of Business & Professional Licensing, DCCED

Cheryl Corrick or Deborah Schneider, CDM Board

April 16, 2015

Dear Honorable Senators of the Finance Committee,

Please accept my apologies for missing the HB 26 hearing yesterday (Wednesday, 4/15). I had minor surgery in the morning, but I appreciate you allowing Deborah Schneider from our Board to testify in my stead. For the past 7 years, I have served on the State's Board of Certified Direct-entry Midwives, the last few as the chair. I am a 42 year Fairbanks resident, married to a lifelong Alaskan, and have 7 Alaskan children, ages 8 – 38 years old. My husband and I spent the past 4 decades working professionally with thousands of Alaskan families and children. I share this introduction to give context in stating my Board service is one of my most rewarding and challenging experiences in serving Alaska's families. I want to address some of the questions and issues raised in considering our Board's extension to 2017. I would be happy to discuss these matters, or any others, with this committee or its individual members.

Certified Direct-entry Midwives (CDM) receive thorough "technical training" and hands-on experience (including at least 60 births), but also undergo a rigorous education as part of apprenticeship. The use of nationally recognized curricula, tests, classes, and self-study culminates in a National 8 hour exam administered by the National Association of Registered Midwives. Ensuring this extensive training (including continuing education) is met to obtain or maintain licensure is, as testified, a major element of this Board's responsibilities. However, the Board also regularly reviews and updates regulations to reflect current best practices, handles investigative case disposition, reviews and approves apprentice permits, examines/approves/renews curriculum for apprenticeship academic programs, writes and updates the Jurisprudence exam for licensee renewal, liaisons with the Midwives Association of Alaska for Peer Review of referred cases, and much more.

To address some other questions from yesterday's hearing, I did work with Budget and Audit staff to complete our last audit. The main reason they recommended only a 2 year extension was investigations issues, an area we labored to redress with little authority to bring change. Investigations were taking extreme lengths of time, regardless of the remedies we sought. One of their attempts was to send our 2 highest priority individuals (4 cases) to OSPA where they languished for over a year. Our "highest priority" turned out to be OSPA's *lowest* priority (a Class B misdemeanor). Ms. Angela Birt (Chief of Investigations) graciously took full responsibility, though she was new to her office, and owned it to us as entirely the Investigative Unit's fault. She has since worked very effectively with us to improve response time and reduce costs for our investigations.

The other major contributor to not only investigative costs, but administrative costs and burden overall, was our former licensing examiner. She referred many minor infractions easily resolvable by the Board (paperwork errors, minor mistakes, deadlines, etc.) directly to Investigations. She also referred excessively to legal, created extra work for the Board and staff by micromanaging and taking over what were actually Board duties (e.g. the apprentice approval referred to in the Legislative Audit), and constantly created/took on unnecessary tasks the Board never requested. After trying to resolve these issues for years, she was recently removed as our licensing examiner. We deeply appreciate the efforts of Ms. Sara Chambers of DCBPL for not only helping end this matter, but also implementing administrative changes and working with us to reduce costs and

improve efficiency. We are confident, with Ms. Chamber's and Ms. Birt's support, we will see dramatic improvements in all areas of Board operation.

These audit recommendations regarding Investigations and apprentice approval illustrate a salient fact and challenge. This volunteer board of an OB/Gyn doctor, a Certified Nurse Midwife, 2 CDMs, and 1 public member, utterly depends on State staff to operate effectively and efficiently. Direct Board costs to meet or teleconference are about \$6,000 per year. All other costs are driven by staff decisions or other factors simply not in our control. Investigative costs, for example, include investigating unlicensed practitioners *who are not even members of our profession*. We can no more influence or change them than the Medical Board can "doctors" with no license. We also repeatedly requested raising apprenticeship fees commensurate with CDM fees (at ½ CDM rate for apprentices) only to be denied several times until the last licensing period. Finally, as our previous licensing examiner demonstrated, we really have no recourse if staff will not follow our directives unless some superior intervenes. Please recognize this reality as you make your decision about extension.

I understand there may have been anecdotal sharing about specific situations with poor outcomes for midwife delivered babies. I strongly encourage any committee member to talk with me or do their own research about the statistical *reality*. Our State's statistics, as well as those of our own and other developed nations, overwhelmingly demonstrate the *average* outcomes for midwife deliveries compare with the *best* individual hospital outcomes in complications, additional medical problems, and the like. This reality holds true, even factoring in that midwives do not serve high risk pregnancies or deliveries. As just one example, our birth center averages 3-5 % caesarian sections compared to 30% caesarian rates in the hospital. CDMs, as a group, are licensed, highly educated and trained professionals who value public safety. The actual record bears out that it is statistically safer and less costly to deliver in a birth center or at home with a licensed, certified midwife.

It is my opinion, with current budgetary constraints, that this volunteer Board, if allowed to follow through on what we started, is an absolute bargain to our state. Without us, the State's cost to administer this profession, manage investigations, consult with professionals, and keep regulations current with best practices would be exorbitant. In addition, the profession we regulate saves the State millions of dollars annually in Medicaid costs compared to hospitals and doctors. Finally, we help cover a potentially huge State liability in public health and safety. As a current example, if this Board sunsets halfway through implementing Senator Kelly's milestone (for our profession) SB156, which passed last July, it would leave old restrictions on Midwife practice removed from statute without new regulations in place to cover such practices. These new regulations are written, but were repeatedly sent back via the paralegal and aforementioned licensing examiner. Because of statute, the Board can and has directed licensees to continue following previous restrictions. If we cease to exist, the work is left undone with an arguable opening for previously restricted practices.

In closing, I hope this letter alleviates potential concerns and clarifies some matters. Please pass HB26 as recommended by Legislative Audit so our current and future measures may resolve the identified issues. I am at your service for anything you require to reach that decision. Thank you for your consideration.

Cheryl Corrick, CDM
Chair, Board of Certified Direct-entry Midwives



Juneau Family Health and Birth Center

1601 Salmon Creek Ln, Juneau, AK 99801 call: 907.586.1203 fax: 907.586.5765 www.juneaubirthcenter.org

April 16, 2015

Good Morning -

I wish to write today to express great concern for HB26, a bill that will extend the Certified Direct-Entry Midwifery Board to provide a safe oversight on the practice of midwifery in this state. The Board consists of five volunteer members, including Direct-Entry Midwives, Certified Nurse-Midwives, and an OB/GYN. It is imperative that this board continue to function for midwives to remain safe, professional, and up to date in our practices.

I have personally attended many board meetings and bear witness that the board is actively working to reduce their operating costs. These costs were driven up by a State administrator who was inappropriately referring midwives to investigations - she has since been replaced. The new Chief of Investigations and Sara Chambers, supervisor in the Department of Corporations, Business and Professional Licensing continue to work with the board to improve the investigation process to further reduce cost. I do not want to say that all investigations are unnecessary - these must continue to take place to ensure that *all* professionals are held accountable in their actions and are conducting themselves appropriately. Without the oversight of the Board, the practice guidelines for this profession would be more open to individual interpretation, potentially increasing the number of investigations and the cost that the State incurs.

Overall, midwives are a huge cost-saving benefit to this state. Numerous studies have proven that midwives are a safe, affordable option for maternity care. Midwifery care shows reduced maternal and infant morbidity and decreases costly interventions such as cesarean section and neonatal intensive care unit admission for newborns. Because a large number of midwifery patients are covered through Medicaid, this savings is passed along directly to the State of Alaska.

I strongly advocate for the passing of HB26. There are greater financial costs to losing this Board than there are financial benefits.

Sincerely,

Madison Nolan, CDM, CPM

Doniece Gott

From: Sen. Anna MacKinnon
Sent: Friday, April 17, 2015 8:41 AM
To: Doniece Gott
Cc: Erin Shine
Subject: FW: Please support HB 26: Extend the CDM Board

From: Diana Rossmiller [mailto:dianarossmiller@gmail.com]
Sent: Thursday, April 16, 2015 10:09 PM
To: Sen. Anna MacKinnon
Subject: Please support HB 26: Extend the CDM Board

Dear Senator Anna MacKinnon,

When I was pregnant, I chose to receive midwifery care from a certified direct-entry midwife for myself and my family. My midwife was licensed through the state of Alaska and provided me with a safe and affordable birth as well as prenatal and postnatal care.

I believe that women should have access to midwifery services. Midwifery care greatly reduces the incidence of costly interventions, such as c sections or neonatal intensive care. These savings are passed on directly to the State for clients who are eligible for Medicaid insurance coverage. The Certified Direct Entry Midwifery Board regulates the midwives in our state, and works to improve the standard of care through regulation. I believe that the continuation of this board is critical to the well being of Alaska's women and children. Please give HB 26 your strongest support!

Thank you for your support of this legislation.

Sincerely,

Diana Rossmiller
8844 N. Douglas Hwy.
Juneau, AK 99801
(907) 723-0235

Greetings,

This is in regards to HB26, the Sunset Bill for Certified Direct-Entry Midwives (CDM). I am asking you to support this bill and get it passed through the finance committee.

Our board is necessary to insure Alaska's CDM laws remain professional and current. The members of our board consist of and OB/GYN, a CNM and five volunteers that meet two times a year. They also have teleconference calls, which the bottom line; DECREASES THE COST for legal, consulting, and administrative costs should this profession be regulated by the department of corporations, businesses, and professional licensing (DCBPL).

Our board has worked diligently in the past years to maintain a safe, professional standard of care for families who choose to birth out of hospital. Our board, along with the new Chief of Investigations, Angela Birt, and supervisor of DCBPL, Sara Chambers have worked to decrease the budget deficit that was inflicted by the past licensing examiner. The board has put a lot of effort into the house keeping of regulations for CDM's. The modification to the CDM regulations are in limbo at this time, and should we lose the Power and Wisdom of the CDM Board, the profession of CDM's will be vulnerable.

Certified Direct-Entry Midwives are important to families who choose to birth in Birth Centers or at home. Through the years CDM's have saved millions of dollars in Medicaid by decreasing the rising incident of cesareans.

Alaska stands out across America for the highest rate of out-of-hospital births attended by a midwife. I am asking you to help protect and grow this statistic by approving HB26.

Vote YES on HB26!

Sincerely,

LeShine Herfindahl, CDM, BSN
P.O. Box 287
Girdwood, AK 99587

Doniece Gott

From: Erin Shine
Sent: Thursday, April 16, 2015 5:24 PM
To: Senate Finance Committee
Subject: FW: Please Pass HB 26!!!

-----Original Message-----

From: Sen. Anna MacKinnon
Sent: Thursday, April 16, 2015 11:18 AM
To: Erin Shine
Subject: FW: Please Pass HB 26!!!

-----Original Message-----

From: lorna mazoff [mailto:lorna_midwife@yahoo.com]
Sent: Thursday, April 16, 2015 11:14 AM
To: Sen. Anna MacKinnon
Subject: Please Pass HB 26!!!

April 16, 2015

Sen. MacKinnon, Sen. Kelly, Sen. Micciche, Sen. Bishop, Sen. Dunleavy, Sen. Hoffman, and Sen. Olson.

Dear Senators of the Finance Committee,

Please help pass HB 26! The members of the Midwives Association of Alaska are hoping that you will see the importance of maintaining the Board of Direct Entry Midwives. We in the field have been busy with our midwifery practices, and were not aware of the tentative state our Board, and this Bill that holds its fate, were in. We have leaned on our representative Board members, Cheryl Corrick and Deborah Schneider, to speak for us to you, but today I invite you to hear the chorus of voices that is behind them. Do not assume the lack of contact from myself or other midwives, or sleep-deprived clients (your constituents) with happy, healthy newborns in arms, as a sign of disinterest. Today we may be busy attending births, but I speak for all the members of Midwives Association of Alaska when I express deep concern that we could lose our Board.

We are a profession with relatively few licensees (who pay one of the highest licensing fees), but what we do is big in Alaska. Some communities (Mat-Su valley area) have the highest rates of midwife-attended out-of-hospital births per capita in the country. With the regulatory guidance of the state Midwifery Board, the members of the Midwives Association of Alaska embody the highest standards in midwifery care. We have a Board with representation of nurse-midwifery, obstetric, and public/consumer stake holders, who work to keep the Certified Direct-Entry laws current and professional. Just last year the legislative session passed the midwifery bill, which now the Board is working to implement by amending the Regulations changes required by the new law. I have attended the Midwifery Board meetings for years and watched them work efficiently and effectively on many issues, including finances. They are diligent in finding ways to bring the Board into financial balance, even when costs are incurred out of their control.

The importance of keeping this Board is without question when one considers the number of healthy, low-risk women who seek midwifery care in Alaska. Midwifery needs to be regulated by a state board that understands both the professional practice of midwifery and the necessity of protecting the public.

Please pass HB26!

Sincerely,

Lorna Mazoff, CDM

MotherWise Midwifery
719 5th St Juneau AK 99801

www.motherwisebaby.com

Doniece Gott

From: Erin Shine
Sent: Thursday, April 16, 2015 5:24 PM
To: Senate Finance Committee
Subject: FW: HB26
Attachments: Letter to Finance Committee.docx

From: Susan Wallen
Sent: Thursday, April 16, 2015 9:34 AM
To: Erin Shine
Subject: FW: HB26

FYI -

Susan Wallen

Executive Assistant
Office of Senator Anna MacKinnon
(formerly Fairclough)
907-465-3777
Susan.Wallen@akleg.gov
Sen.Anna.MacKinnon@akleg.gov

From: Alaska Birthing [<mailto:alaskabirthing@aol.com>]
Sent: Thursday, April 16, 2015 9:10 AM
To: Susan Wallen
Subject: HB26

Dear Senator MacKinnon,

I sent this attached letter to you and all the senators on the Finance Committee last night, but I see that I misspelled your name in the address, and this letter did not go thru to you. My sincere apologies for misspelling your name.

Please read the attached letter and pass HB26 thru your committee.

Thank you for the work you do in service to the people of Alaska.

Sincerely,
Susan Terwilliger
President of The Midwives Association of Alaska (MAA)

Susan Terwilliger LM,CPM,CDM
Alaska Birthing, midwifery care for homebirth
11517 Old Glenn Highway, Eagle River, AK 99577

907-694-1123
alaskabirthing.com

Doniece Gott

From: Erin Shine
Sent: Thursday, April 16, 2015 6:17 PM
To: Senate Finance Committee
Subject: FW: Pass HB26

-----Original Message-----

From: Sen. Anna MacKinnon
Sent: Thursday, April 16, 2015 5:56 PM
To: Doniece Gott
Cc: Erin Shine
Subject: FW: Pass HB26

-----Original Message-----

From: Sarah Chamberlain [mailto:sbchamberlainphoto@gmail.com]
Sent: Thursday, April 16, 2015 5:55 PM
To: Sen. Anna MacKinnon; Sen. Pete Kelly; Sen. Peter Micciche; Sen. Click Bishop; Sen. Mike Dunleavy; Sen. Lyman Hoffman; Sen. Donny Olson; Sen. Bill Stoltze
Subject: Pass HB26

Our family moved here last Spring and found out that we were expecting right away. When I began to feel that our safety and consent was not number one at our assigned hospital, I looked into the local midwiferies and birth centers. Never in my life have I EVER felt so supported as a patient and so safe in knowing that I was cared for by knowledgeable, well researched midwives. Alaska is definitely doing something right with their board of midwives! Please pass HB26!

Sincerely,

--

Sarah Beth Chamberlain
SB Photography
(607)280-0657



Juneau Family Birth Center

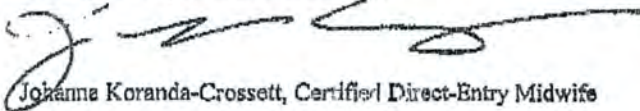
3225 Hospital Drive, Suite 106, Juneau, AK 99801 (907)586-1203

Dear Senate Finance Committee Members,

April 16, 2015

I am writing in support of the passage of HB 26 and the extension of the Board of Direct-Entry Midwives of Alaska. Since the Division of Legislative Audit's recommendations regarding investigations have been addressed by the Department of Commerce and Community Services as stated yesterday by Ms. Chambers during the SFC hearing on HB 26, I opine that the two-year extension of the board is in the best interest of the public. Mothers and babies are best served by regulated midwives and midwives are best regulated by a professional board consisting of health care professionals as opposed to DCCED employees alone. Perhaps a solution lies in reducing or eliminating the Board's travel costs, if the fiscal note is a concern to the committee. I believe that the state will indeed save money by extending the board as well-regulated midwives will be less likely to go to investigation. This Board is working and Alaska needs and wants midwives. Statistics for out-of-hospital births are well documented. Please see the attached study from the Journal of Midwifery and Women's Health.

Thank you for your time and service,



Johanna Koranda-Crossett, Certified Direct-Entry Midwife

Improving Quality and Safety in Maternity Care: The Contribution of Midwife-Led Care

Jane Sandall, RM, RN, MSc, PhD, Declan Devane, RM, Hora Soltani, RM, MMedSci, PhD, Marie Hatem, RM, PhD, and Simon Gates, PhD

This article draws on findings from a recent Cochrane systematic review of midwife-led care and discusses its contribution to the safety and quality of women's care in the domains of safety, effectiveness, woman-centeredness, and efficiency. According to the Cochrane review, women who received models of midwife-led care were nearly eight times more likely to be attended at birth by a known midwife, were 21% less likely to experience fetal loss before 24 weeks' gestation, 19% less likely to have regional analgesia, 14% less likely to have instrumental birth, 18% less likely to have an episiotomy, and significantly more likely to have a spontaneous vaginal birth, initiate breastfeeding, and feel in control. In addition to normalizing and humanizing birth, the contribution of midwife-led care to the quality and safety of health care is substantial. The implications are that policymakers who wish to improve the quality and safety of maternal and infant care, particularly around normalizing and humanizing birth, should consider midwife-led models of care and how financing of midwife-led services can support this. Suggestions for future research include exploring why fetal loss is reduced under 24 weeks' gestation in midwife-led models of care, and ensuring that the effectiveness of midwife-led models of care on mothers' and infants' health and well-being are assessed in the longer postpartum period. *J Midwifery Womens Health* 2010;55:255-261 © 2010 by the American College of Nurse-Midwives.

Keywords: humanized care, midwife-led care, physiologic birth, quality, safety

INTRODUCTION

Maternal and perinatal morbidity and mortality together represent one of the biggest challenges to public health, particularly in low-income countries.¹ However, the evidence base on safety, its root causes and contributing factors, and the most cost-effective solutions to common problems is very limited. As a result, research on maternal and neonatal care has been identified by the World Health Organization (WHO) Patient Safety Programme as one of the top 20 global research priorities in low-income countries or countries with economies that are in transition. However, the actual quality of care for healthy women, which constitute the majority of women worldwide, has received relatively less research attention.² This article discusses some of the findings of a recent Cochrane review on midwife-led models of care in relation to dimensions of quality and safety in maternity care.

IMPROVING QUALITY AND SAFETY IN MATERNITY CARE

The concepts of childbirth safety and normalizing and humanizing childbirth are often presented in oppositional terms as though to achieve a safe birth requires that a woman may have to compromise on the experience of a physiologic birth.³ Safety is often presented as an absence of harm rather than a positive aspect of the birth experience. For example, in 2002, WHO Member States agreed on a World Health Assembly resolution on patient safety, defined as "the reduction of risk of unnecessary

harm associated with healthcare to an acceptable minimum."⁴ When safety is conceptualized in terms of risk management activities, midwives and birthing women can experience surveillance and medical dominance.⁵ This dichotomizing of the issues leads to a narrow approach to exploring the experiences of all childbearing women, including those who are healthy, and a lack of understanding around when and where women feel safe in giving birth. In relation to maternity care, it would seem more fruitful to conceptualize the concepts of safety and quality in a holistic way drawing upon ideas of social and cultural safety.⁶

Quality of health care has been conceptualized in a more holistic multidimensional way. For example, the Institute of Medicine (IOM), the health arm of the US National Academy of Sciences, defines quality of health care as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."⁷ In its report "Crossing the quality chasm," the IOM called for large-scale changes to the US health care system and laid out six national aims for improvement: safety, effectiveness, patient-centeredness (referred to as woman-centeredness in this article), timeliness, efficiency, and equity. Within maternity care, the UK maternity policy "Maternity matters" focuses on improving quality and safety of care.⁸ In the United States, the landmark report "Evidence-based maternity care: What it is and what it can achieve" highlights that nearly all women who give birth in US hospitals experience high rates of interventions, with risks of adverse effects. Procedures appropriate for a relatively small number of mothers, such as episiotomy and continuous electronic fetal monitoring, are common. This report notes that optimal maternity care should

Address correspondence to Jane Sandall, RM, RN, MSc, PhD, Department of Primary Care and Public Health Sciences, King's College London, 42 Weston St., London SE1 3QD. E-mail: jane.sandall@kcl.ac.uk

follow the principle of "effective care with least harm" and that "numerous beneficial practices that support women's own innate capacities or the physiologic process of childbirth," such as labor support, are underused.⁹

In many parts of the world, emphasis has been placed on the difficulties with ensuring a trained and knowledgeable workforce.¹⁰ Improving the availability of skilled midwifery care has been identified by WHO and a range of other agencies as an important priority. However, there is less understanding of how such care should be organized, and how midwifery care can contribute to improvements in safety and quality. In addition, the concept of quality has broad implications for women's choices, because emerging evidence indicates alarming rates of increasing caesarean sections, especially in places where medical models are dominant.¹¹

THE COCHRANE REVIEW ON MIDWIFE-LED CARE COCHRANE VERSUS OTHER MODELS OF CARE FOR CHILDBEARING WOMEN AND THEIR INFANTS

This article draws upon findings from a recent Cochrane review of midwife-led models of care that synthesized information on differences in maternal and perinatal morbidity and mortality, effectiveness, and psychosocial outcomes.¹² The review compared midwife-led models of care with other models of care for childbearing women and their infants, and investigated whether effects of midwife-led care were influenced by: 1) differing levels of continuity, 2) varying levels of obstetric risk, and 3) practice setting (community- or hospital-based). The review also included a narrative evaluation of cost implications.

In the review, models of care were classified as "midwife-led" or "other" based on the lead professional providing care in both the antepartum and intrapartum periods. The rationale for this classification is that decisions and actions taken in pregnancy affect intrapartum events. Models of care were defined in the following ways:

- a) Midwife-led care, where the midwife is the woman's lead professional, but one or more consultations with medical staff are often included as part of routine practice;

- b) Obstetrician-led care, which is common in North America, wherein obstetricians are the primary providers of antenatal care for most childbearing women. An obstetrician (not necessarily the one who provides antenatal care) is present for the birth, and nurses provide intrapartum and postnatal care;
- c) Family doctor-led care, with referral to specialist obstetric care as needed. Obstetric nurses or midwives provide intrapartum and immediate postnatal care but not at a decision-making level, and a medical doctor is present for the birth; and
- d) Shared models of care, where responsibility for the organization and delivery of care, throughout initial booking to the postnatal period, is shared between different health professionals.

The review summarized 11 trials involving 12,276 women that took place in public health systems in four countries (the United Kingdom, Canada, New Zealand, and Australia). The review included trials with women classified as being at "low" and "mixed" risk of complications. "Other" models of care included shared and medical-led care. Midwife-led models of care included team and caseload midwifery. In team midwifery, a woman receives her care from a number of midwives in the team, the size of which can vary. In caseload midwifery, a woman receives her antenatal, intrapartum, and postnatal care from one midwife and back-up practice partner(s).

None of the trials included models of care that offered home birth, although some offered intrapartum care in a midwife-led birth center in a hospital. In addition, the place of antenatal and postnatal care varied (Table 1).

Details of the design and methodology can be found in the full review.¹² The review included published and unpublished studies, and Cochrane quality criteria were used to assess trials for inclusion in the review.

WHAT DOES MIDWIFE-LED CARE CONTRIBUTE TO QUALITY AND SAFETY IN MATERNITY CARE?

Drawing on a previously published discussion,¹³ this section examines findings of the Cochrane review specifically in relation to four of the IOM-defined dimensions of quality: safety, effectiveness, woman-centeredness, and efficiency. Table 2 classifies findings from the Cochrane review according to these dimensions.⁷

Safety

Safety is defined as "avoiding injuries to patients from the care that is intended to help them."¹⁴ Women randomized to midwife-led models of care were less likely to experience fetal loss or neonatal death at less than 24 weeks' gestation (eight trials; $N = 9890$; risk ratio [RR] = 0.79; 95% confidence interval [CI], 0.65–0.97; fixed effects analysis; Figure 1).

Jane Sandall, RM, RN, MSc, PhD, is a professor of Social Science and Women's Health and Innovations Programme Director, King's Patient Safety and Services Quality Research Centre, King's College London, London, UK.

Declan Devane, RM, is a senior lecturer in the School of Nursing and Midwifery, Áras Moyola, National University of Ireland, Galway, Galway, Ireland.

Hani Sultani, RM, MMedSci, PhD, PG Dip (Health Care Education), is a reader in the Centre for Health and Social Care Research at the Faculty of Health and Wellbeing, Sheffield Hallam University, Sheffield, UK.

Marie Hatem, RM, PhD, is a professor in the Department of Social and Preventive Medicine, University of Montreal, Montreal, Quebec, Canada.

Simon Oates, PhD, is a Principal Research Fellow at the Health Sciences Research Institute, Warwick Medical School Clinical Trials Unit, Warwick University, Warwick, UK.

Table 1. Details of 11 Trials in Cochrane Review of Midwife-Led Care Versus Other Models of Care for Childbearing Women and Their Infants

Countries, n	
Australia	4
Canada	1
New Zealand	1
United Kingdom	5
Risk status, n	
Low	6
Mixed	5
Women attended by a known carer, %	
Midwife-led	63-98
Other models	0.3-21
Types of midwife-led models of care, n	
Team	9
Case-load	2
Types of other models of care, n	
Shared care	7
Medical-led	3
Medical-led and shared care	1
Midwife-led models of care, setting for Intrapartum care, n	
Hospital home-like unit	3
Hospital labour ward	8
Midwife-led models of care, setting for antenatal and postnatal care, n	
All hospital based	4
Antenatal care in community and no community postnatal care	1
Antenatal and postnatal care in community	3
Antenatal care in hospital and postnatal care in community	3

Source: Hatem et al.¹²

There were no statistically significant differences between groups for overall fetal loss or neonatal death equal to or greater than 24 weeks' gestation. There was no increased likelihood for any adverse outcome for women or their infants associated with having been randomized to a midwife-led model of care. These results were moderate in magnitude and generally consistent across all the trials.

Effectiveness

Effectiveness is defined as "providing services based on sound scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively)."⁷

Women randomized to midwife-led models of care were less likely to experience: regional analgesia/anesthesia (11 trials; N = 11,892; RR = 0.81; 95% CI, 0.73-0.91; random effects analysis), an instrumental (forceps or vacuum) birth (10 trials; N = 11,724; RR = 0.86; 95% CI, 0.78-0.96; fixed effects analysis; Figure 2), and an episiotomy (11 trials; N = 11,872; RR = 0.82; 95% CI, 0.77-0.88; fixed effects analysis). However, there were no significant differences in the caesarean section rate (11 trials; N = 11,897; RR = 0.96; 95% CI, 0.87-1.06; fixed effects analysis).

In addition, women randomized to midwife-led models of care were more likely to experience no intrapartum regional analgesia/anesthesia (five trials; N = 7039; RR = 1.16; 95% CI, 1.05-1.29; fixed effect analysis; Figure 3), a spontaneous vaginal birth (nine trials; N = 10,926; RR = 1.04; 95% CI, 1.02-1.06; fixed-effect analysis), and breastfeeding initiation (one trial; N = 405; RR = 1.35; 95% CI, 1.03-1.76; random-effects analysis).

Woman-Centeredness

Woman-centeredness is defined as "providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions."⁷ Women randomized to midwife-led models of care were more likely to experience high perceptions of control during labor (one trial; n = 471; RR = 1.74; 95% CI, 1.32-2.30; fixed effects analysis) and attendance at birth by a known midwife (six trials; n = 5525; RR = 7.84; 95% CI, 4.15-14.81; random-effects analysis; Figure 4). Levels of continuity, as measured by the percentage of women who were attended during birth by a known carer, varied from 63% to 98% for midwife-led models of care and from 0.3% to 21% in other models of care.

Women's reported experiences of care included maternal satisfaction with information, advice, explanation, venue of delivery, and preparation for labor and birth, as well as perceptions of choice for pain relief and evaluations of carer's behavior. In the majority of the included studies, satisfaction in various aspects of care appeared to be higher in the midwife-led models compared to the other models of care.

Efficiency

Efficiency is defined as avoiding waste, including waste of equipment, supplies, ideas and energy.⁷ Five trials presented cost data using different economic evaluation methods. All of the five trials that assessed costs suggest a cost-saving effect in intrapartum care for midwife-led models of care compared to other models of care. One trial suggested a higher cost and one trial no differences in cost of postnatal care when midwife-led care was compared with medical-led maternity care. There was a lack of consistency in estimating maternity care cost among the

Table 2. Findings of the Cochrane Review on Midwife-Led Care Classified by Four Dimensions of Quality of Care

Safe	Effective	Woman-Centred	Efficient
Fetal loss	Evidence-based care	Experience and satisfaction	Staff resource use
Perinatal mortality	Physiologic birth	Sense of control	Length of stay
Perinatal morbidity	Breastfeeding	Continuity of care by a known midwife	Readmission
Maternal morbidity	—	—	Antenatal hospitalization

Sources: Institute of Medicine² and Halem et al.¹²

available studies; however, there seemed to be a trend towards the cost-saving effect of midwife-led care in comparison with medical-led care.

Women randomized to midwife-led models of care were less likely to experience antenatal hospitalization (five trials; N = 4337; RR = 0.90; 95% CI, 0.81–0.99; fixed effects analysis; Figure 3). In addition, infants of women randomized to midwife-led models of care had a shorter mean length of stay in hospital (two trials; N = 259; weighted mean difference [WMD] –2.00 days; 95% CI, –2.15 to –1.85; random effects analysis) than infants of women randomized to other models of care.

THE EFFECT OF BACKGROUND RISK, CONTINUITY, AND CARE PROVISION IN COMMUNITY SETTINGS

It was hypothesised that differential effects and outcomes could be related to three factors. First, the levels of continuity with care provider (caseload models of care offer higher levels of relationship continuity); second, whether women are low- or mixed-risk; and third, whether any care is provided in a community-based practice setting.

When the sub-group analyses were conducted, the risk ratio for fetal loss or neonatal death at greater than or equal to 24 weeks' gestation was 0.48 (95% CI, 0.23–1.03) in the caseload trials, and 1.44 (95% CI, 0.86–2.42) in the team trials. In the analysis of the proportion of neonates with 5-minute Apgar score <7, the RR was 0.62 (95% CI, 0.38–1.02) in one caseload trial and 1.40 (95% CI, 0.97–2.01) in the team trials.

However, the significance of the analyses of individual sub-groups is not a reliable guide to whether the treatment effects differ between sub-groups, because nonsignificance may be caused by a small sample size (and therefore wide CIs). Interaction tests provide a more appropriate test of differences between the sub-groups, but need to be interpreted with caution because the number of outcome events influence interaction tests, and in these analyses was low. Subgroup analyses are by their nature observational (not randomized), and the increase in the number of analyses performed caused by sub-group analyses can lead to some statistically significant results arising by chance. When these were conducted, there was a statistically significant difference in the treatment effects between team and caseload models of midwife-led care for 5-minute Apgar scores <7 (interaction chi-square = 5.62; P = .02), and fetal loss and neonatal death at greater than or equal to 24 weeks' gestation (interaction chi-square = 5.25; P = .02) as shown in Figure 6.

There was no evidence of any difference in treatment effects between the sub-groups for any other outcome, and other effects were consistent by level of risk, practice setting, and organization of care, suggesting that the effectiveness of midwife-led models of care is maintained for women classified both as low- and mixed-risk, and in both community- and hospital-based settings.

DISCUSSION

Policy makers and health care providers want to improve the quality of maternity care; however, there has been a range of definitions of quality. Drawing on the six

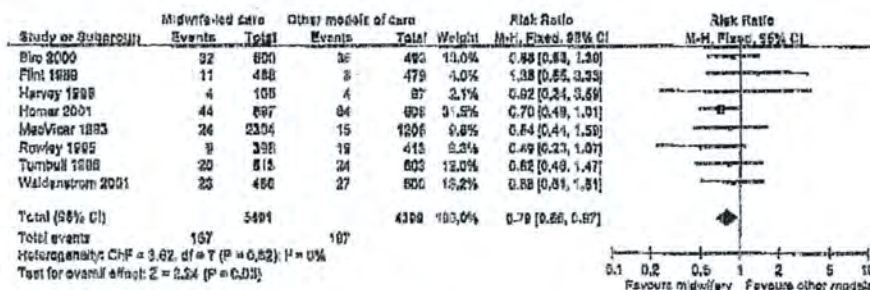


Figure 1. Midwife-led versus other models of care for childbearing women and their infants – fetal loss or neonatal death less than 24 weeks. Source: Halem M, Sandell, J. (Joint First Author and Contact Author) Devane D, Soltani H, Gates, S. (2008) Midwife-led versus other models of care for childbearing women, Cochrane Database of Systematic Reviews 2008, Issue 4, Page 40.

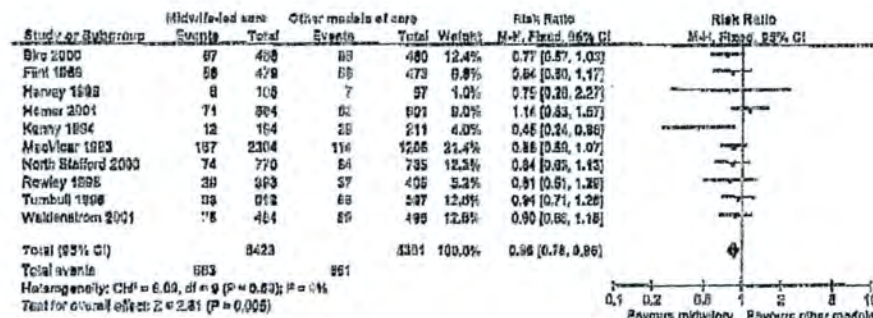


Figure 2. Midwife-led versus other models of care for childbearing women and their infants - instrumental birth. Source: Hatem M, Sandall, J. (Joint First Author and Contact Author) Devane D, Soltani H, Gates, S. (2008) Midwife-led versus other models of care for childbearing women, Cochrane Database of Systematic Reviews 2008, Issue 4, Page 50.

dimensions of quality as defined by the IOM allows for some comparisons with similar work in mainstream health care to be made.

In summary women who received models of midwife-led care were nearly eight times more likely to be attended at birth by a known midwife, 21% less likely to have a fetal loss before 24 weeks' gestation, 19% less likely to have regional analgesia, 14% less likely to have instrumental birth, 18% less likely to have an episiotomy, and significantly more likely to have a spontaneous vaginal birth, initiate breastfeeding, and feel in control. Midwife-led models were generally cheaper, and women and infants spent significantly less time in hospital. Overall, there was no increased likelihood for any adverse outcome for women or their infants associated with having been randomized to a midwife-led model of care. These results were moderate in magnitude and generally consistent across all the trials.

When outcomes for women who received team midwifery were compared with women who received caseload midwifery, women who received team midwifery were significantly more likely to have a fetal loss after 24 weeks' gestation and for their infants to have significantly lower Apgar scores.

The review concluded that most women should be offered midwife-led models of care, and that women should be encouraged to ask for this option, although caution should be exercised in applying this advice to women

with substantial medical or obstetric complications. It is important to note that the findings of the review cannot be generalized to models of midwife-led care that include homebirth.

Policy makers and health care providers should be aware that such benefits are conferred whether midwives provide antenatal care in hospital or community settings. Not all areas of the world have health systems where midwives are able to provide midwife-led models of care, and health system financing is a potential barrier to implementation. Policy makers who wish to improve the quality and safety of maternal and infant care, particularly around normalizing and humanizing birth, should consider midwife-led models of care and how financing of midwife-led services can support this.

The implications are that increasing the number of women who have access to midwife-led care will improve the quality of care they receive. This would increase the number of women who have a physiologic birth and report a good birth experience. The challenge is that in the majority of countries in the world, service reconfiguration will be required to deliver models of care that offer continuity of care by midwives.

IMPLICATIONS FOR RESEARCH

In terms of safety, an intriguing question remains about why fetal loss is reduced under 24 weeks' gestation in

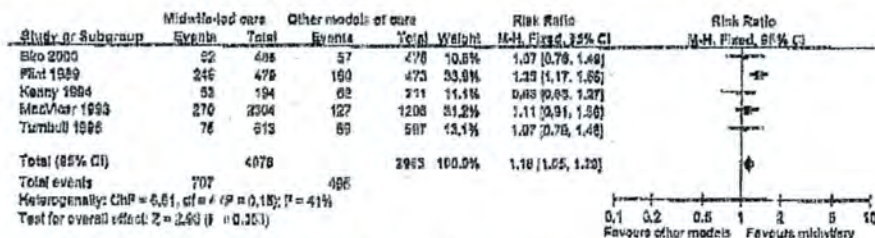


Figure 3. Midwife-led versus other models of care for childbearing women and their infants - no regional analgesia/anesthesia. Source: Hatem M, Sandall, J. (Joint First Author and Contact Author) Devane D, Soltani H, Gates, S. (2008) Midwife-led versus other models of care for childbearing women, Cochrane Database of Systematic Reviews 2008, Issue 4, Page 44.

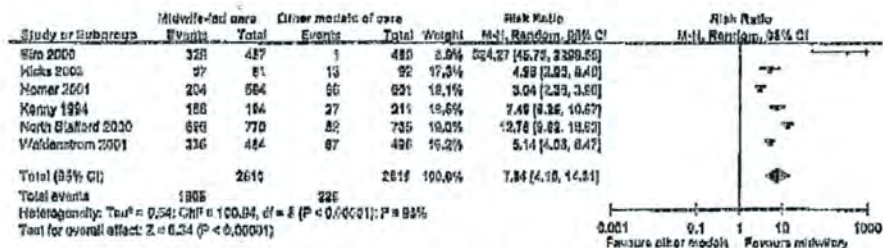


Figure 4. Midwife-led versus other models of care for childbearing women and their infants – Attendance at birth by a known midwife. Source: Hatem M, Sandell, J. (Joint First Author and Contact Author) Devane D, Sofkani H, Gates, S. (2008) Midwife-led versus other models of care for childbearing women, Cochrane Database of Systematic Reviews 2008, Issue 4, Page 49.

midwife-led models of care. Future research in this area would benefit from drawing on a framework for trials of complex interventions, which explicitly requires theoretic modeling between processes and outcomes in the pretrial stage in terms of what the hypothesized mechanisms might possibly be.

There remains relatively little information about the effectiveness of midwife-led models of care on mothers' and infants' health and well-being in the longer postpartum period. Future research should pay particular attention to outcomes that have been underresearched but are causes of significant morbidity, including urinary and fecal incontinence, duration of caesarean incision pain, pain during intercourse, prolonged perineal pain, and birth injury (to the infant).

In terms of women-centeredness and humanized care, little is known about maternal self-confidence, post-traumatic stress disorder, and coping after the birth, or whether women feel they are part of the decision-making process. There is wide variation in the instruments used to measure women's views and experiences of care. There is a need for future trials to use meaningful, robust, valid, and reliable methods to assess psychosocial outcomes and well-being in pregnant and childbearing women.

Given the heterogeneity in the choice of outcome measures routinely collected and reported in randomized evaluations of models of maternity care, a core (minimum) dataset would be useful not only within multicenter trials and for comparisons between trials, but might also be a sig-

nificant step in facilitating useful meta-analyses of similar studies.¹⁵ In addition, future trials should include measures of optimal outcomes for mothers and infants in addition to measures of morbidity.

In assessing efficiency, there is a lack of consistency in estimating maternity care cost, and further research using standard approaches of cost estimation is required, which also includes cost to women and families. All trials should include economic analyses of the relative costs and benefits. There were no trials in resource-constrained countries, and additional trials may be required in such settings.

There is no evidence in the Cochrane review regarding impact on timeliness and equity; however, midwife-led services have the potential to reduce disparities and improve timeliness in relation to early antenatal care and maternal and fetal well-being and parenting. Future trials should assess the effect of models of care equity and timeliness.

Although continuity of care has been identified as a core component of midwife-led care, there is wide variation in the definition and measurement of continuity of care, which will require greater sophistication in future studies. All future trials should provide greater description of the models of care being assessed and how they are being delivered. Future research should also assess acceptability to midwives of different models of midwife-led care that offer relational continuity.

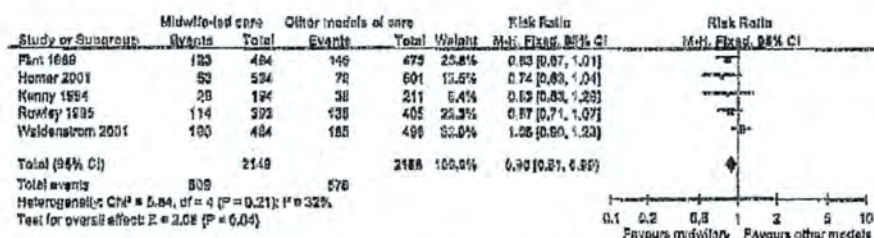


Figure 5. Midwife-led versus other models of care for childbearing women and their infants – Antenatal hospitalisation. Source: Hatem M, Sandell, J. (Joint First Author and Contact Author) Devane D, Sofkani H, Gates, S. (2008) Midwife-led versus other models of care for childbearing women, Cochrane Database of Systematic Reviews 2008, Issue 4, Page 39.

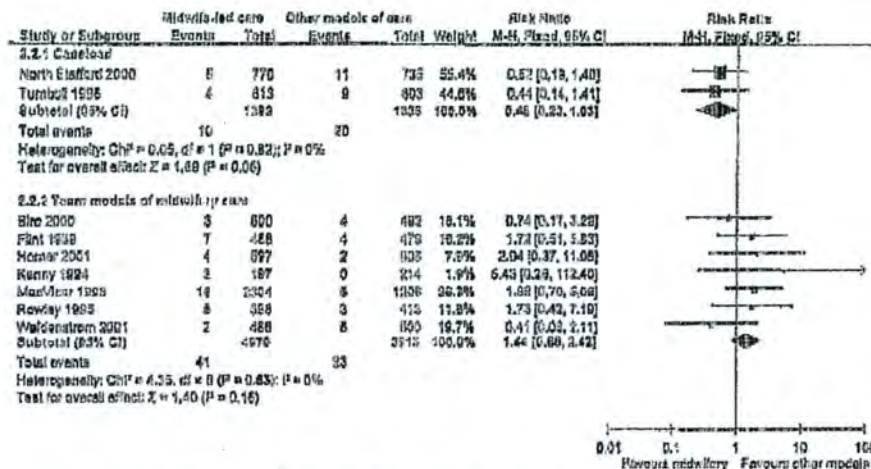


Figure 6. Midwife-led versus other models of care: variation in midwifery models of care (caseload/one-to-one or team) fetal loss/neonatal death equal to/after 24 weeks. Source: Hatem M, Sandall J, (Joint First Author and Contact Author) Devane D, Soltani H, Gates S. (2008) Midwife-led versus other models of care for childbearing women, Cochrane Database of Systematic Reviews 2008, Issue 4, Page 65.

REFERENCES

1. Lawn JB, Cousens S, Zupan J, Lancet Neonatal Survival Steering Team. 4 million neonatal deaths: When? Where? Why? *Lancet* 2005;365:891-900.
2. Althabe F, Bergel E, Cafferata ML, Gibbons L, Ciapponi A, Alemán A, et al. Strategies for improving the quality of health care in maternal and child health in low- and middle-income countries: An overview of systematic reviews. *Paediatr Perinat Epidemiol* 2008;22(Suppl 1):42-60.
3. Waldenström U. Modern maternity care: Does safety have to take the meaning out of birth? *Midwifery* 1996;12:165-73.
4. World Health Organization Web site. Quality of care: Patient safety. Report by the Secretariat. Fifty-fifth World Health Assembly, provisional agenda item 13.9. Available from: http://apps.who.int/ghiarchival/pdf_files/WHA55/ea5513.pdf [Accessed February 15, 2010].
5. Annandale E. How midwives accomplish natural birth: Managing risk and balancing expectations. *Social Problems* 1988; 35:95-110.
6. De Vries RA. *pleasing birth: Midwives and maternity care in the Netherlands*. Philadelphia: Temple University Press, 2005.
7. Institute of Medicine. *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academy Press, 2001.
8. Department of Health /Partnerships for Children, Families and Maternity Web site. *Maternity matters: Choice, access and continuity of care in a safe service*. Available from: www.dh.gov.

ukidr_consum_dhlgroupstdh_digitalassets@dhl@enldocuments.digitalassetdh_074199.pdf [Accessed February 15, 2010].

9. Sakala C, Conry MP. *Evidence-based maternity care: What it is and what it can achieve*. Childbirth Connection, New York, Milbank Memorial Fund. Available from: www.childbirthconnection.org/pdfs/evidence-based-maternity-care.pdf [Accessed February 15, 2010].
10. World Health Organization Web site. Global priorities for research in patient safety research (first edition). The Research Priority Setting Working Group, December 2008. Available from: www.who.int/patientsafety/research/priorities/global_priorities_patient_safety_research.pdf [Accessed September 23, 2009].
11. Ribeiro VS, Figueiredo FP, Silva AA, Bettiol H, Batista RF, Colmba LC, et al. Why are the rates of cesarean section in Brazil higher in more developed cities than in less developed ones? *Braz J Med Biol Res* 2007;40:1211-20.
12. Hatem M, Sandall J, Devane D, Soltani H, Gates S. Midwife-led versus other models of care for childbearing women. *Cochrane Database Syst Rev* 2008;4:CD004667.
13. Sandall J, Hatem M, Devane D, Soltani H, Gates S. Discussions of findings from a Cochrane review of midwife-led versus other models of care for childbearing women: Continuity, normality and safety. *Midwifery* 2009;23:8-13.
14. Vincent C. *Patient safety*. London: Churchill Livingstone, 2006.
15. Devane D, Begley CM, Clarke M, Horey D, OBoyle C. Evaluating maternity care: A core set of outcome measures. *Birth* 2007; 34:164-72.

TRANSACTION REPORT

APR-16-2015 THU 11:03 AM

FOR: 907 465 2187

SENATE FINANCE

RECEIVE

DATE	START	SENDER	RX TIME	PAGES	NOTE
APR-16	10:58 AM	9075865765	5'46"	9	OK

ALASKA STATE LEGISLATURE

LEGISLATIVE BUDGET AND AUDIT COMMITTEE

Division of Legislative Audit



P.O. Box 113300
Juneau, AK 99811-3300
(907) 465-3830
FAX (907) 465-2347
legaudit@akleg.gov

SUMMARY OF: A Sunset Review on the Department of Commerce, Community, and Economic Development, Board of Certified Direct-Entry Midwives, June 30, 2014

PURPOSE OF THE REPORT

In accordance with Title 24 and Title 44 of the Alaska Statutes (sunset legislation), we have reviewed the activities of the Department of Commerce, Community, and Economic Development's (DCCED) Board of Certified Direct-Entry Midwives (board). The purpose of this audit was to determine if there is a demonstrated public need for the board's continued existence and if it has been operating in an effective manner. As required by AS 44.66.050(a), this report shall be considered by the committee of reference during the legislative oversight process in determining whether the board should be reestablished. Currently, under AS 08.03.010(c)(8), the board will terminate on June 30, 2015, and will have one year from that date to conclude its administrative operations.

REPORT CONCLUSIONS

Overall, the audit concluded that the board is serving the public's interest by effectively licensing certified direct-entry midwives (CDM) and apprentices. Furthermore, the board worked to improve the profession by modifying and adopting midwifery regulations to conform with current standards of care. The audit also concluded that Division of Corporations, Business and Professional Licensing (DCBPL) staff failed to operate in the public's interest by not pursuing timely disciplinary sanctions related to four CDM investigations. We recommend the board's termination date be extended only two years to June 30, 2017. The reduced extension recommendation is due to significant deficiencies by DCBPL staff in pursuing disciplinary sanctions.

FINDINGS AND RECOMMENDATIONS

1. DCCED's commissioner should take immediate action to pursue disciplinary sanctions for CDM cases when warranted.
2. DCBPL, in consultation with the board, should increase licensing fees to eliminate the board's operating deficit.

3. The board should communicate certificate requirements to continuing education providers to facilitate compliance with centralized licensing regulations.
4. The board should approve apprentice permit applications in accordance with statutes.

ALASKA STATE LEGISLATURE

LEGISLATIVE BUDGET AND AUDIT COMMITTEE

Division of Legislative Audit



P.O. Box 113300
Juneau, AK 99811-3300
(907) 465-3830
FAX (907) 465-2347
legaudit@akleg.gov

July 21, 2014

Members of the Legislative Budget
and Audit Committee:

In accordance with the provisions of Title 24 and Title 44 of the Alaska Statutes (sunset legislation), we have reviewed the activities of the Board of Certified Direct-Entry Midwives and the attached report is submitted for your review.

DEPARTMENT OF COMMERCE, COMMUNITY,
AND ECONOMIC DEVELOPMENT
BOARD OF CERTIFIED DIRECT-ENTRY MIDWIVES

June 30, 2014

Audit Control Number
08-20089-14

The audit was conducted as required by AS 44.66.050 and under the authority of AS 24.20.271(1). Per AS 08.03.010(c)(8), the Board of Certified Direct-Entry Midwives is scheduled to terminate on June 30, 2015. We recommend the legislature extend the termination date to June 30, 2017.

The audit was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Fieldwork procedures utilized in the course of developing the findings and recommendations presented in this report are discussed in the Objectives, Scope, and Methodology.

A handwritten signature in black ink, appearing to read "Kris Curtis".

Kris Curtis, CPA, CISA
Legislative Auditor

TABLE OF CONTENTS

	<u>Page</u>
Objectives, Scope, and Methodology	1
Organization and Function	5
Report Conclusions.....	7
Findings and Recommendations.....	9
Analysis of Public Need	13
Agency Responses:	
Department of Commerce, Community, and Economic Development	21
Board of Certified Direct-Entry Midwives	23

OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with Title 24 and 44 of the Alaska Statutes, we have reviewed the activities of the Board of Certified Direct-Entry Midwives (board) to determine if there is a demonstrated public need for its continued existence and if it has been operating in an efficient and effective manner.

As required by AS 44.66.050(a), this report shall be considered by the committee of reference during the legislative oversight process in determining whether the board should be reestablished. Currently, under AS 08.03.010(c)(8), the board will terminate on June 30, 2015, and will have one year from that date to conclude its administrative operations.

Objectives

The four central, audit objectives were:

1. Determine whether the board's termination date should be extended.
2. Determine whether the board is operating in the public's interest.
3. Determine whether the board has exercised appropriate regulatory oversight of licensed and apprenticed midwives.
4. Provide a current status of recommendations made in the prior sunset audit.

Scope and Methodology

The assessment of board operations and performance 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 a board.

The audit reviewed board operations and activities from FY 10 through March 31, 2014.

During the course of the audit, the following were reviewed and evaluated:

- Applicable statutes and regulations to identify board functions and responsibilities. Changes made during the audit period were reviewed to determine whether the changes enhanced or impeded board activities and to ascertain if the board operated in the public's interest.

- Board member applications and resumes filed with the Office of the Governor's Board and Commissions to verify that members met statutory requirements.
- Board meeting minutes and annual reports to understand board proceedings and activities as well as the nature and extent of public input.
- Public notice documentation to determine whether public notice for board meetings and regulatory changes were published as required by Alaska Statutes and Division of Corporations, Business and Professional Licensing (DCBPL) policies.
- The prior sunset audit report to identify issues affecting the board.

The current board chair and former public board member were interviewed to gain an understanding of the board's activities, the level of public input, and changes in fee levels. DCBPL's director, various other DCBPL personnel, and several employees in the information technology section of the Department of Commerce, Community, and Economic Development's (DCCED) Administrative Services Division were interviewed to assess the adequacy of DCBPL's support for board activities. Additionally, inquiries with agency staff at the Department of Law's Office of Special Prosecution and Appeals were conducted to determine the current status of certified direct-entry midwives cases forwarded by DCBPL investigative staff.

A random sample of six initial and renewal licensing files was selected from 52 active licenses and assessed for statutory and regulatory compliance. In determining sample size, the applicable controls were considered moderately significant; the inherent risk was considered limited; and the risk of noncompliance was considered low.

Twenty-six complaints against board licensees, applicants, or unlicensed individuals were either open or opened by DCBPL between July 1, 2009, and February 28, 2014. A judgmental sample of eight complaints was selected, and investigative files and documentation were tested to assess the efficiency and effectiveness of the investigative process. Prior audits found errors with the case management system. Therefore, when determining sample size, the risk of noncompliance was considered moderate, and a sample of 30 percent (8) was determined sufficient to detect errors. Three complaints were randomly selected, and five complaints open over a year were selected.

Board and DCBPL internal control procedures relating to various audit objectives, including procedures over licensing, investigations, and board proceedings, were assessed. Controls over the investigative case management system and the licensing database were also assessed.

Inquiries regarding board-related complaints were made with the following organizations:

- Alaska State Commission for Human Rights;

- Department of Administration's Division of Personnel and Labor Relations;
- United States Equal Employment Opportunity Commission;
- DCCED's Commissioner's Office;
- Office of the Ombudsman;
- Office of Victims' Rights; and
- Office of the Governor's Boards and Commissions.

(Intentionally left blank)

ORGANIZATION AND FUNCTION

The Board of Certified Direct-Entry Midwives (board) was established under the provisions of Title 8, Chapter 65 of the Alaska Statutes. The board is composed of five members; two certified direct-entry midwives (CDM), one physician licensed by the State Medical Board,¹ one certified nurse midwife licensed by the Board of Nursing, and one public member.

Board members are appointed by the governor to serve staggered four-year terms. Board members may not serve more than two consecutive terms. A public member may not be engaged in the midwifery profession, have association by legal contract with a midwife, or have a direct financial interest in the midwifery profession. Members of the board, as of June 30, 2014, are listed in Exhibit 1.

Board Duties and Powers

Alaska Statute 08.65.030 establishes the board's authority. This authority includes:

1. Issuing midwife licenses and apprentice permits to qualified applicants.
2. Establishing, amending, or eliminating regulations that affect the midwifery practice's professional standards.
3. Taking disciplinary action when a person violates midwifery-related statutes or regulations.
4. Adopting standards for basic education, training, and apprentice programs.
5. Reviewing and approving continuing education courses.

Department of Commerce, Community, and Economic Development (DCCED), Division of Corporations, Business and Professional Licensing (DCBPL)

DCBPL provides administrative and investigative assistance to the board. Administrative assistance includes budgetary services and functions such as collecting fees, maintaining files, receiving and issuing application forms, and publishing examination and meeting

¹The physician is required to have an obstetrical practice or specialized training in obstetrics.

Exhibit 1

<p>Board of Certified Direct-Entry Midwives as of June 30, 2014</p> <p>Cheryl Corrick <i>Certified Direct-Entry Midwife, Chair</i></p> <p>Deborah Schneider <i>Certified Direct-Entry Midwife</i></p> <p>Peggy A. Downing <i>Physician</i></p> <p>Sarah J. Taygan <i>Certified Nurse Midwife</i></p> <p>Jennifer A. Swander <i>Public Member</i></p>

notices. Investigative assistance is available upon request, or DCBPL may initiate an investigation if an individual appears to have engaged or is about to engage in a practice over which DCBPL has authority. DCBPL can issue an order that an individual stop a practice, bring an action in Alaska's Superior Court to enjoin the act, examine a license holder and/or an association's books and records, and subpoena witnesses and records.

Alaska Statute 08.01.065 mandates that DCCED adopt regulations to establish the amount and manner of fee payments for applications, examinations, licenses, registration, permits, investigations, and all other fees as appropriate for the occupations covered by statutes.

REPORT CONCLUSIONS

In developing our conclusions, we evaluated the Board of Certified Direct-Entry Midwives' (board) operations using the 11 factors set out in AS 44.66.050. Under the State's "sunset" law, these factors are to be used to assess whether an agency has demonstrated a public policy need for continuing operations.

Overall, the audit concluded that the board is serving the public's interest by effectively licensing certified direct-entry midwives (CDM) and apprentices. Furthermore, the board worked to improve the profession by modifying and adopting midwifery regulations to conform with current standards of care. The audit also concluded that Division of Corporations, Business and Professional Licensing staff failed to operate in the public's interest by not pursuing timely disciplinary sanctions related to four CDM investigations.

In accordance with AS 08.03.010(c)(8), the board is scheduled to terminate June 30, 2015. We recommend the board's termination date be extended only two years to June 30, 2017. The reduced extension recommendation is due to significant deficiencies by DCBPL staff in pursuing disciplinary sanctions. (See Recommendation No. 1.) Additionally, we noted operational improvements and fee increases are needed. (See Recommendation Nos. 2 through 4.)

(Intentionally left blank)

FINDINGS AND RECOMMENDATIONS

No recommendations were made as part of the Board of Certified Direct-Entry Midwives (board) 2006 sunset audit. This audit includes five new recommendations.

Recommendation No. 1

The Department of Commerce, Community, and Economic Development's (DCCED) commissioner should take immediate action to pursue disciplinary sanctions for certified direct-entry midwives (CDM) cases when warranted.

Disciplinary sanctions were not actively pursued for four CDM-related investigations which were completed during the audit period. The investigations, involving two people, supported disciplinary sanctions including probation with continuing education and license revocation. However, Division of Corporations, Business and Professional Licensing (DCBPL) investigative staff did not actively pursue disciplinary sanctions to protect the public's safety.

The duty to investigate occupational licensing complaints is statutorily assigned to DCBPL. The efficiency with which complaints are investigated is one evaluation criteria used in the legislative sunset oversight process. Specifically, AS 44.66.050(c) requires examining:

The efficiency with which public inquiries or complaints regarding the activities of the board, commission, or agency filed with it, with the department to which a board or commission is administratively assigned, or with the office of victims' rights or the office of the ombudsman have been processed and resolved.

DCBPL has standard procedures to investigate occupational licensing complaints. Once an investigation is complete, a board member reviews the evidence to ensure the proposed action to resolve a case is appropriate. If evidence is determined sufficient, a board member will recommend the investigator pursue a consent agreement (CA)² with the respondent. Where appropriate, CA's are used to avoid the additional use of time and resources associated with litigation.

If a respondent refuses the terms of a CA, the investigator requests an assistant attorney general (AAG) review the evidence to determine if it is legally sufficient for adjudication. If the AAG concludes that the evidence is legally sufficient, the AAG prepares an accusation for DCBPL to file. The litigation phase begins with DCCED's commissioner filing an

²A CA is a signed agreement between the respondent and DCCED's commissioner in which the respondent agrees to the facts of the case and to the proposed decision and disciplinary sanctions. The board must review the signed CA and may reject or adopt it through a board order issued during a public meeting.

accusation with the board. After an accusation is filed, a respondent has 15 days from the accusation receipt date to file a notice of defense. If the respondent requests a hearing, an AAG is assigned to represent DCCED, and the Office of Administrative Hearings (OAH) is notified that a hearing was requested. Alaska Statute 44.64.060(d) mandates that an OAH judge conduct a hearing and issue a proposed decision within 120 days from the date the hearing was requested. The board has 45 days to adopt or amend the proposed decision or to require additional proceedings.

In all four CDM cases, the respondents refused to sign a CA. Rather than file an accusation and pursue an administrative hearing, DCBPL staff followed alternate procedures. Two of the four cases were forwarded to the Department of Law's Office of Special Prosecutions and Appeals (OSPA) without a sufficiency of evidence review by an AAG. A year after the cases were forwarded to OSPA, no action had been taken. According to OSPA, the cases represent their lowest priority as the related offenses were categorized as Class B misdemeanors. The other two cases were held by DCBPL investigators with the understanding that the cases would be forwarded to OSPA once the other cases were addressed. Due to staff turnover, it is unclear why DCBPL staff did not pursue a civil licensing action as required by standard operating procedures. At a minimum, licensing action should be pursued concurrently to ensure the public is protected from incompetent, negligent, or unlicensed practitioners. By not pursuing licensing action, the respondents were allowed to continue practicing, and the public's safety was placed at risk. Risk was further increased in that the two respondents were also licensed to train apprentice midwives.

We recommend DCCED's commissioner take immediate action to pursue disciplinary sanctions for CDM cases when warranted.

Recommendation No. 2

DCBPL, in consultation with the board, should increase licensing fees to eliminate the board's operating deficit.

Occupational fees did not cover the cost of regulating the board. As of March 31, 2014, the board had an operating deficit of \$115,261. Alaska Statute 08.01.065(c) requires DCCED to set occupational fees so that fees collected approximately equal the board's regulatory costs.

The sufficiency of licensing fees has been an ongoing issue for the board. Historically, expenditures have significantly fluctuated depending on the board's investigative and regulatory activities. During the audit period, licensing fees increased in FY 11 and again in FY 13; however, the fee increases were insufficient to cover the board's regulatory costs.

Expenditures for administrative and investigative activities resulted in an operating deficit. Without further increases to licensing fees, a significant deficit will remain, shifting regulatory costs to future licensees.

We recommend DCBPL, in consultation with the board, increase licensing fees to eliminate the board's operating deficit.

Recommendation No. 3

The board should communicate certificate requirements to continuing education providers to facilitate compliance with centralized licensing regulations.

An examination of DCBPL's continuing education audit function found that the board accepted proof of continuing education that did not comply with centralized licensing regulations. Continuing education certificates for two of two licensees tested were missing activity descriptions and the instructor, sponsor, or other verifier's mailing addresses.

Centralized licensing regulation 12 AAC 02.960(e) states, in part, that a licensee selected for audit will be notified of the following by DCCED.

Within 30 days of notification, the licensee shall submit to the department, documentation to verify completion of the continuing competency activities claimed on the statement submitted with the application for license renewal. The documentation must include a valid copy of a certificate or similar verification of satisfactory completion of the continuing competency activities claimed that provides

- (1) The name of the licensee;*
- (2) The amount of continuing competency credit awarded;*
- (3) A description of the continuing competency activity;*
- (4) The dates of actual participation or successful completion; and*
- (5) The name, mailing address and signature of the instructor, sponsor, or other verifier.*

Certificates were missing information because providers were unaware of the requirements. The board did not communicate continuing education certificate requirements to the approved providers due to not understanding centralized licensing regulations. Incomplete certificates do not provide adequate evidence that a licensee met continuing education requirements. Furthermore, incomplete certificates increase administrative costs due to the licensing examiner needing to research and follow-up missing information to verify classes taken by a licensee complied with continuing education requirements.

We recommend the board communicate certificate requirements to continuing education providers to facilitate compliance with centralized licensing regulations.

Recommendation No. 4

The board should approve apprentice permit applications in accordance with statutes.

For two of two apprentice applications tested, permits were inappropriately issued by DCBPL's licensing examiner rather than by the board.

Board regulation 12 AAC 14.130(c) allows the DCBPL licensing examiner to review apprentice permit applications; however, the regulation does not authorize the licensing examiner to approve permits. Furthermore, per AS 08.65.030(a)(3), only the board has authority to approve permits.

The board adopted regulation 12 AAC 14.130(c) with the intent of delegating approval authority to DCBPL under the incorrect understanding that such delegation was legal. Once the regulation passed, DCBPL's licensing examiner proceeded to review and approve permit applications. Misapplication of regulatory language resulted in apprentices being issued permits without the oversight of experienced board members.

We recommend the board approve apprentice permit applications in accordance with statutes.

A ANALYSIS OF PUBLIC NEED D

The following analysis of the Board of Certified Direct-Entry Midwives (board) activities relate to the public need factors defined in AS 44.66.050(c). This analysis is not intended to be comprehensive but to address those areas we were able to cover within the scope of our review.

Determine the extent to which the board, commission, or program has operated in the public interest.

The board operated in the public's interest by licensing qualified individuals, modifying and adopting regulations to improve midwifery practices, and holding meetings as required by statutes.

From FY 10 through March 31, 2014, the board met at least twice per year as statutorily required. A quorum was established at all meetings, and all board vacancies were filled in a timely manner. A review of two board member applications found both members were appointed in compliance with statutory requirements.

The board further operated in the public's interest by reviewing peer review reports submitted by the Midwives Association of Alaska (MAA) to ensure that licensed certified direct-entry midwives (CDM) met peer review requirements. *Peer review* is a method used by the board to ensure that the quality of care provided by licensed CDMs meets midwifery care standards.

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

Board operations were impeded by high regulatory costs relative to the low number of licensees. This has been an ongoing challenge. In the 2006 sunset audit, the board operated in a deficit even though license fees were the highest of any profession at \$2,088 per license.

Exhibit 2 (following page) presents a schedule of board revenues and expenditures from FY 10 through March 31, 2014. The amounts were provided by Division of Corporations, Business and Professional Licensing (DCBPL) management and are unaudited. The information is provided for general informational purposes.

The exhibit shows that the board remained in a deficit position from FY 10 through March 31, 2014. During that time, expenditures increased approximately 270 percent. As of March 31, 2014, the board had an operating deficit of \$115,261. Expenditure increases were mainly due to regulatory and investigative activities.

Exhibit 2

Board of Certified Direct-Entry Midwives Schedule of Revenues and Expenditures FY 10 through March 31, 2014 (Unaudited)					
	<u>FY 10</u>	<u>FY 11</u>	<u>FY 12</u>	<u>FY 13</u>	<u>July 1, 2013 - March 31, 2014</u>
Licensing Revenue	\$ 3,080	\$ 43,695	\$ 5,290	\$ 51,545	\$ 2,970
Direct Expenditures					
Personal Services	16,488	22,654	34,945	53,564	27,433
Travel	5,028	4,090	8,520	4,793	3,035
Contractual	1,020	4,656	5,544	6,580	2,092
Supplies	64	-	-	24	12
Total Direct Expenditures	22,600	31,400	49,009	64,961	32,572
Indirect Expenditures*	2,585	2,700	3,459	3,946	2,959
Total Expenditures	25,185	34,100	52,468	68,907	35,531
Annual Surplus (Deficit)	<u>(22,105)</u>	<u>9,595</u>	<u>(47,178)</u>	<u>(17,362)</u>	<u>(32,561)</u>
Beginning Cumulative Surplus (Deficit)	<u>(5,651)</u>	<u>(27,756)</u>	<u>(18,161)</u>	<u>(65,339)</u>	<u>(82,701)</u>
Ending Cumulative Surplus (Deficit)	<u>\$ (27,756)</u>	<u>\$ (18,161)</u>	<u>\$ (65,339)</u>	<u>\$ (82,701)</u>	<u>\$ (115,262)</u>

Source: DCBPL management.

*FY 14 indirect expenditures are estimated based on the prior fiscal year's amount.

Alaska Statute 08.01.065(c) states DCCED shall establish fees “so that the total amount of fees collected for an occupation approximately equals the actual regulatory costs of the occupation.” Exhibit 3 (following page) presents the board’s schedule of licensing fees from FY 10 through FY 14. The exhibit highlights that initial midwife certification and biennial renewal fees increased from \$500 during FY 10 to \$1,250 in FY 11. Fees increased again to \$1,450 in FY 13. However, fee increases were not adequate to cover the board’s regulatory costs. (See Recommendation No. 2.)

Exhibit 3

Board of Certified Direct-Entry Midwives					
License Fees					
FY 10 through FY 14					
Fee Type	FY 10	FY 11	FY 12	FY 13	FY 14
Nonrefundable Midwife Application Fee	\$ 100	\$ 250	\$ 250	\$ 250	\$ 250
Midwife Initial Certification and Renewal Fee	500	1,250	1,250	1,450	1,450
Nonrefundable Apprentice Application Fee	50	125	125	125	125
Apprentice Permit and Renewal Fee	50	125	125	125	125

Source: DCBPL management

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

During the audit period, the board initiated a statutory revision project which resulted in Senate Bill (SB) 156 being introduced in February 2014. The bill increased qualified preceptor requirements, moved the codification of required practices from statutes to regulations, amended the definition of *practice of midwifery*, and removed cultural exemptions. The bill passed in April 2014.

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

From FY 10 through March 31, 2014, the board held nine regular meetings and three emergency teleconference meetings. All regular meetings were published at least 10 days in advance of the meeting date on the State’s Online Public Notice System and in the *Anchorage Daily News*. Additionally, all three teleconference meetings were published at least five days in advance of the meeting date. The board encouraged public participation by allotting time for public comment during all board meetings.

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

The board consistently published proposed regulation changes on the State’s Online Public Notice System and in the *Anchorage Daily News* at least 30 days before the adoption date as statutorily required. Furthermore, the board encouraged public participation by providing the opportunity to submit written comments on proposed regulatory changes.

Determine the efficiency with which public inquiries or complaints regarding the activities of the board, commission, or agency filed with it, with the department to which a board or commission is administratively assigned, or with the office of victims' rights or the office of the ombudsman have been processed and resolved.

No board-related complaints were filed with the State's Office of the Ombudsman, Office of Victims' Rights, Office of the Governor, or the Department of Commerce, Community, and Economic Development, Commissioner's Office from FY 10 through February 28, 2014.

Twenty-six complaints against board licensees, applicants, or unlicensed individuals were either open or opened by DCBPL from FY 10 through February 28, 2014. All but four of the complaints were either closed or open for a reasonable amount of time as of February 28, 2014. The audit found that, although investigations supported disciplinary sanctions, DCBPL investigative staff did not actively pursue sanctions to protect the public's safety in four cases. Instead of following standard operating procedure which calls for licensing sanctions through the attorney general's office and the Office of Administrative Hearings, DCBPL forwarded two of the cases to the Office of Special Prosecutions and Appeals (OSPA) for criminal proceedings. The two remaining cases were held pending the availability of resources at OSPA. At the time of the audit, the cases had remained at OSPA for a year without action. OSPA, with its limited resources, regards CDM cases as low priority because the alleged offenses were only Class B misdemeanors. (See Recommendation No. 1.) The board inquired regarding the status of the investigations and was told by DCBPL investigative staff that all four cases were at the Department of Law. The board was unaware that DCBPL staff had forwarded two of the four cases to OSPA.

Determine the extent to which a board or commission that regulates entry into an occupation or profession has presented qualified applicants to serve the public.

As shown in Exhibit 4 (following page), from FY 10 through FY 13, the board issued 40 new licenses. Eleven of these were midwife licenses, and 29 were apprentice permits. As of March 31, 2014, there were 35 licensed CDMs and 13 apprentice midwives.³

CDM applicants may be licensed either through examination or based on professional credentials. Testing of two license applications and three license renewal applications concluded that the board reviewed and approved license and license renewal applications in accordance with statutes and regulations.

Licensed CDMs are subject to peer review per regulation 12 AAC 14.900. The board designated the MAA to review the quality of care provided by a CDM. During peer review, the MAA reviews birth summaries submitted by CDMs, and if considered necessary, birth charts are also reviewed. Our examination of peer review reports for three licensees showed that peer reviews were completed in accordance with statutes and regulations.

³The prior sunset audit reported 28 midwives and eight apprentices as of June 30, 2006. The count as of March 31, 2014, represents a 25 percent increase in licensed midwives and a 62 percent increase in permitted apprentices over approximately eight years.

Exhibit 4

New Midwife Licenses and Apprentice Permits Issued FY10 through FY13						
License Type	FY10	FY11	FY12	FY13	Total Issued FY10 – FY13	Total Licenses (as of March 31, 2014)
Midwives	3	4	2	2	11	35
Apprentices	8	12	2	7	29	13
Totals	11	16	4	9	40	48

Source: BCDEM annual reports and DCBPL’s licensing database

To promote continued competency, all licensees are required to comply with continuing education requirements when renewing licenses. Ten percent of license renewals are subject to a continuing education audit each biennial licensing cycle. Two of two licensees’ continuing education certificates tested did not comply with centralized licensing regulations because they did not contain all of the required information. (See Recommendation No. 3.)

Examination of two apprentice permit applications showed that the permits were issued by the licensing examiner without the board’s approval. The board adopted regulation 12 AAC 14.130(c) with the intent of delegating authority to issue apprentice permits to the licensing examiner; however, statutes do not authorize the licensing examiner to issue permits. (See Recommendation No. 4.)

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

From FY 10 through February 28, 2014, no board-related complaints were filed with the Alaska State Commission for Human Rights, the United States Equal Employment Opportunity Commission, or the Department of Administration’s Division of Personnel and Labor Relations.

Determine the extent to which statutory, regulatory, budgeting, or other changes are necessary to enable the agency, board, or commission to better serve the interests of the public and to comply with the factors enumerated in this subsection.

Recommendation No. 1 discusses DCBPL’s need to improve investigative case management procedures and oversight to ensure DCBPL provides adequate investigative support to the board. Furthermore, as identified in a prior special audit,⁴ case confidentiality in DCBPL’s

⁴Department of Commerce, Community and Economic Development; Division of Corporations, Business, and Professional Licensing; Select Occupational Licensing and Enforcement Issues, June 29, 2011, Audit Control Number 08-30063-11

investigation database is weak. Though investigators are discouraged from viewing cases to which they are not assigned, they have view and change capabilities to all electronic investigative files. Per DCBPL's director, the need to reassign cases among investigators is essential for managing investigative work loads, and therefore, DCBPL has chosen to assume the related risk.

Additionally, Recommendation Nos. 2 through 4 address changes needed to improve the board's operational activities to better serve the public.

Determine the extent to which the board, commission, or agency has effectively attained its objectives and purposes and the efficiency with which the board, commission, or agency has operated.

The board identifies goals and objectives each year in its annual report. The board established three general goals: carry out the board's assigned duties; work toward keeping license fees low to promote entry into the profession; and identify future projects such as needed regulatory and statutory changes. Review of board meeting minutes, annual reports, and inquiries with board members and DCBPL staff indicate that the board actively worked towards accomplishing its planned goals and objectives. Significant accomplishments related to the board's goals include:

- Successfully recommended statutory updates that were enacted through the passage of SB 156 in April 2014;
- Modified and adopted regulations that reflect current practice and safety protocols for the midwifery profession;
- Approved additional courses of study for providers to ensure that educational courses to promote competency in the midwifery profession are available for licensees; and
- Revised peer review processes which include improvements to peer review reports and the creation of new forms for providing summaries of the peer reviews conducted on CDMs. The peer review committee uses the forms to ensure an acceptable level of care and safety is being met by licensed CDMs.

Determine the extent to which the board, commission, or agency duplicates the activities of another governmental agency or the private sector.

The board does not duplicate the activities of another governmental or private sector agency as it is the only entity responsible for licensing, regulating, and disciplining midwives in the State.

The board mainly interacts with the North American Registry of Midwives (NARM) and the MAA. *NARM* is a national organization which has a role in the board's licensing process as

new license applicants are required to pass the exam administered and graded by NARM. The MAA performs peer reviews, provides certification opportunities⁵ for applicants to meet licensing requirements, and offers classes to meet continuing education requirements for license renewal. The board does not duplicate NARM and the MAA's efforts. Licensees are not required to be members of either organization.

⁵The MAA provides certification in intravenous therapy treatment for Group B Streptococci, intravenous therapy, and neonatal resuscitation as required by 12 AAC 14.400(4) for CDMs renewing their license.

(Intentionally left blank)



THE STATE
of **ALASKA**
GOVERNOR SEAN PARNELL

Department of Commerce, Community,
and Economic Development

OFFICE OF THE COMMISSIONER

P.O. Box 110800
Juneau, Alaska 99811-0800
Main: 907.465.2500
Programs fax: 907.465.5442

August 26, 2014

RECEIVED

AUG 26 2014

LEGISLATIVE AUDIT

Ms. Kris Curtis, CPA, CISA
Legislative Auditor
Division of Legislative Audit
P.O. Box 113300
Juneau, AK 99811-3300

Re: Preliminary Audit Report, Department of Commerce, Community, and Economic
Development, Board of Certified Direct-Entry Midwives, June 30, 2014, Audit
Control Number 08-20089-14

Dear Ms. Curtis,

Thank you for the opportunity to respond to the auditor's conclusions and recommendations regarding the sunset review of the Board of Certified Direct-Entry Midwives (board). The department concurs that the board serves the public's interest and supports extending the termination date to June 30, 2017. Our comments on the auditor's recommendations are provided below.

Recommendation No.1

The Department of Commerce, Community, and Economic Development's (DCCED) commissioner should take immediate action to pursue disciplinary sanctions for certified direct-entry midwives (CDM) cases when warranted.

The department concurs with this recommendation. The director of the Division of Corporations, Business and Professional Licensing (DCBPL) will take action to ensure compliance that investigators comply with standard procedures. DCBPL has begun working with the Department of Law to pursue civil licensing action on the four cases noted by the auditor in accordance with division policy.

Recommendation No. 2

DCBPL, in consultation with the board, should increase licensing fees to eliminate the board's operating deficit.

The department concurs with this recommendation. DCBPL, with agreement from the board, increased the fee for midwife license. With the board's concurrence, DCBPL intends

Ms. Kris Curtis, CPA, CISA
August 26, 2014
Page 2

to increase the apprentice midwife license fee the next time a fee change regulation is noticed. DCBPL will continue to partner with the board to reduce the operating deficit.

Recommendation No. 3

The board should communicate certificate requirements to continuing education providers to facilitate compliance with centralized licensing regulations.

Although this audit recommendation is directed to the board, DCBPL is committed to protecting consumers will work with the board to improve operational activities.

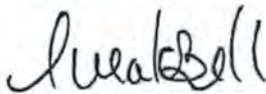
Recommendation No. 4

The board should approve apprentice permit applications in accordance with statutes.

Although this audit recommendation is directed to the board, DCBPL is committed to protecting consumers will work with the board to improve operational activities.

Again, thank you for the opportunity to respond to the audit report conclusions and recommendations. If you have any additional questions, please contact me at 465-2500.

Regards,



Susan K. Bell
Commissioner

Cc: Sara Chambers, Director, Division of Corporations, Business, and Professional Licensing
Jeanne Mungle, Director, Division of Administrative Services

Cheryl Corrick
P.O. Box 81573
Fairbanks, AK 99708

Kris Curtis, CPA, CISA
Legislative Auditor
Division of Legislative Audit
P.O. Box 113300
Juneau, AK 99811-3300

RECEIVED
AUG 20 2014
LEGISLATIVE AUDIT

Dear Ms. Curtis,

Thank you for the opportunity to respond to your audit findings. I will attempt to answer the Findings and Recommendations point by point.

Recommendation No. 1:

I concur with this recommendation. The Board has been concerned with the time and expense of investigations and has expressed those concerns to the Investigators on numerous occasions since I have been on the Board. The Board is also concerned with the potential issue of public safety, although very few details have been made available to the Board since I have been a part of the Board, therefore we really don't have any knowledge as to whether or not there are ongoing public safety issues. The time spent on investigations has been frustrating to the Board and the cost to the profession is more than it should be due to this problem. It is my understanding that the current Chief Investigator has been taking steps to expedite these investigations and reduce cost to the Board and he has taken the time to attend Board meetings and explain this to the Board.

Recommendation No. 2:

I concur with this recommendation, with reservations. The Board has requested that, in addition to the proposed increases in licensing fees for CDMs, the Division also increase apprentice licensing fees to 50% of CDM fees. The Board sees this as a potential way to help meet the shortfall. So far, the Board's request has been denied over the past two years. At this point, the deficit has been allowed to grow to the point that it would not be possible to make up the shortfall within one or two licensing periods. If the Division were to try to raise licensing fees to cover the shortfall too quickly, the licensing fees would be prohibitive for many CDMs and they would not re-license, leaving too few licensees to cover the shortfall and the deficit would remain. I concur that DCBPL, in consultation with the Board, should increase licensing fees with a plan to eliminate the Board's operating deficit over a period of time.

Recommendation No. 3:

I concur with this recommendation. The Board has already taken steps to notify the continuing education providers of the certificate requirements and the Board will not accept incomplete certificates in the future. It was the Board's understanding that all of the providers were aware of the certificate requirements prior to the receipt of incomplete certificates and the Board did not want to penalize the licensees at the time of the audit. The Board is now aware of the problem and has taken steps to resolve it.

Recommendation No. 4:

I concur with this recommendation. The Board now understands that the regulation intending to delegate approval authority to the division was not legal. This Board action was recommended by the licensing examiner and was passed with approval from Legal, which is the standard by which all regulations projects are approved. In the future the Board will approve all apprentice permit applications in accordance with statutes.

In conclusion, I would like to say that my largest concern from the audit findings is that of cost. We are one of the smallest professions with one of the highest licensing fees. The Board is trying to find ways to cut cost, including meeting in the area where the largest number of Board members reside in order to save costs for board meetings; working on a disciplinary matrix to help Investigations with time and cost considerations; and researching the possibility of a legal defense fund to help smaller professions with the cost of investigations. We have also combined regulatory projects and are putting others on hold.

Although I agree with the need to review the progress of this board, particularly regarding the Investigative process, I am concerned with the time and cost of another Audit in such a short period of time.

Again, I appreciate the opportunity to respond to the Audit findings. The Audit team were a pleasure to work with and were very clear about their expectations and findings as well as answering any questions I had.

Sincerely,



Cheryl Corrick, CDM, CPM
CDM Board Chair