

ALASKA LEGISLATURE COMMITTEE FILES 1981-1982 8672

1543 SHESS SB 747 (#2)

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STATE COMMISSION OF
NURSING SUPERVISORS

Provisional
Requirements

Regular
Requirements

- 602.05. Postpartum home visits (within 36 hours of delivery) 10 30
- 602.06. ECDC Department of Pediatrics NICU and Nursery (8 hours minimum). Other acceptable observations entities will be considered May be done during registration period Required at application
- 602.07. ECDC Department of Obstetrics and Gynecology High Risk perinatal Unit observation entities will be considered May be done during registration period Required at application
- 602.08. Observation of one complete series of prepared childbirth classes May be done during registration period 1-6 hour class series preferred
- 602.09. Observation of one complete La Leche League series May be done during registration period 1 series of 4 meetings
- 602.10. Five experiences in each of categories 602.01, 02, 03 and 04 must be with an approved physician or certified midwife trainer. Required at application.

603. SUPERVISION OF CLINICAL EXPERIENCE* Clinical experience may be obtained under the supervision of a physician, certified nurse-midwife or registered lay midwife. This must be direct, present in the same room supervision. Those providing supervision must be approved by the Division for training and should have had previous experience with home birth. Postpartum home visit supervision may be provided by an HCD public health nurse.

604. CONTINUING EDUCATION: Continuing education is required for annual renewal of registration.
- 604.01. In each calendar year, eight contact hours of continuing education must be obtained. One hour each of management of antepartum, intrapartum, and newborn periods and one hour of recognition and management of emergency situations must be obtained: other hours may cover any topics applicable to midwifery practice.
 - 604.02. Continuing education may be obtained through convention, conferences, area midwives meetings or other mechanism as approved by the Division.
 - 604.03. In any calendar year the Department may require specific topics for continuing education based upon any problem areas indicated by registered lay midwives' semi-annual reports.
700. REQUIREMENTS OF EXAMINATION: Any person applying for regular registration, as a lay midwife must pass a qualifying examination administered under the auspices of the Department. The Department shall offer the examination at least twice a year.
701. FIELDS TESTED: The examination shall consist of three parts:
- 701.01. A written examination designed to test knowledge in theory regarding pregnancy and childbirth;
 - 701.02. An oral examination designed to test clinical judgment in lay midwifery case management; and
 - 701.03. A practical examination designed to demonstrate the mastery of skills necessary for the practice of lay midwifery.
702. SCOPE OF WRITTEN EXAMINATION: The written examination shall cover:
- 702.01. Theory regarding pregnancy and childbirth including but not limited to:
 - 702.01.01. Anatomy and physiology of the female reproductive system, in both pregnant and non-pregnant states;

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- 702.01.02. Normal growth and development of fetus and placenta;
- 702.01.03. Normal progress of pregnancy, labor and delivery;
- 702.01.04. Comfort measures in the antepartum, intrapartum and postpartum periods;
- 702.01.05. Significance of laboratory studies in pregnancy and the neonatal period; and
- 702.01.06. Prenatal nutrition.
- 702.02. Patient teaching;
- 702.03. Special requirements of home delivery;
- 702.04. Risk factors in pregnancy;
- 702.05. Terminology used in the practice of lay midwifery;
- 702.06. Normal newborn characteristics and possible problems including anomalies;
- 702.07. Care of the newborn; and
- 702.08. Pertinent legislation and regulations for lay midwifery in New Mexico.
- 703. SCOPE OF ORAL EXAMINATION: The oral examination shall cover:
 - 703.01. Evaluation of judgment to cover areas of:
 - 703.01.01. Early recognition of abnormalities in the antepartum, intrapartum, postpartum and neonatal periods: their significance and possible sequelae if untreated
 - 703.01.02. Recognition and treatment of emergency situations
 - 703.01.03. Course and management of normal labor and selected normal antepartum situations (nutritional counseling, patient teaching, dealing with normal discomforts).

704. SCOPE OF PRACTICAL EXAMINATION: The practical examination shall cover basic observational skills:

704.01. Temperature, pulse, and respiration

704.02. Blood pressure

704.03. Fetal heart tones

704.04. Abdominal palpation

704.05. Cervical dilatation

704.06. Fetal position

704.07. Measurement of fundal height

704.08. Exam for edema

DUTIES AND RESPONSIBILITIES

800. COVERAGE: The registered lay midwife must assure that all women she plans to deliver receive required tests.

801. MEDICAL EVALUATION: The lay midwife must require the patient to have a risk evaluation and physical examination by a physician before a registered lay midwife assumes her care.

802. REQUIRED TESTS: Initial physician examination shall include clinical pelvimetry and the following laboratory tests -- VDRL, GC screen, blood type and group, hematocrit and hemoglobin, rubella titer and urinalysis. Hematocrit must be rechecked at 28 and 36 weeks gestation.

803. PRENATAL VISITS: Prenatal visits should be every 4 weeks until 28 weeks gestation, every 2 weeks from 28 until 35 weeks gestation and weekly from 36 weeks until delivery.

804. PHYSICIAN VISITS: Each woman must also have one prenatal visit with a physician at 36 to 40 weeks.

805. RECORDS: The lay midwife shall maintain records of physician's visit with evidence of his/her exam for the Division.

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806. ADVANCE PREPARATION FOR NEED: The registered lay midwife, prior to the onset of labor, must have:
- 806.01. Arrangements made for transport of mother and/or infant to a hospital; and
 - 806.02. Agreement for medical referral and/or hospitalization of mother and/or infant, if it should become necessary.
807. INFORMED CONSENT: The registered lay midwife must inform any woman seeking home birth of possible risks of home birth and must obtain informed consent of the woman for home birth prior to the onset of labor on a form provided by the Department.
808. COMMUNITY RESOURCES: The registered lay midwife must be familiar with community resources for pregnant women such as prenatal classes, WIC program, La Leche League and HSD clinics.
809. LATE PREGNANCY PERIOD: The registered lay midwife will make a home visit no more than 4 weeks prior to the EDC to assess the physical environment, to ascertain that the woman has all necessary supplies to prepare the family for the birth and to instruct the family to correct problems or deficiencies.
810. NORMAL DELIVERY: The registered lay midwife must remain with the mother and infant for at least two hours postpartum, or until the mother's fundus is firm and lochia normal, the mother has voided and the infant has a normal temperature and is nursing well, whichever is longer.
811. HOSPITALIZATION: The registered lay midwife must accompany to the hospital any mother or infant requiring hospitalization, giving any pertinent written records and a verbal report to the physician assuming care. If possible, she should remain with the mother and/or infant to ascertain outcome.
812. PHYSICIAN EVALUATION OF NEWBORN: The registered lay midwife must recommend that any infant delivered at home be evaluated by a physician within 3 days of age, or sooner when it becomes apparent that the newborn needs medical attention.
813. POSTPARTUM VISITS: The registered lay midwife shall make postpartum home visits to evaluate the condition of mother and infant at least twice - once within 36 hours of birth and once on the fourth or fifth postpartum day. Additional visits shall be made as indicated.

814. RH BLOOD FACTOR: In the case of an unsensitized Rh negative mother, the registered lay midwife shall:
- 814.01. Obtain a sample of cord blood from the placenta and deliver it to a laboratory within 24 hours of the birth.
 - 814.02. Be certain that the mother consults a physician within 24 hours.
815. PREVENTION OF INFANT BLINDNESS: Within one hour of birth, the registered lay midwife shall administer two drops of 1% solution of silver nitrate or other antiseptic of equal potency and harmlessness into the eyes of the infant in accordance with the Health and Environment Department's Regulations Governing the Prevention of Infant Blindness.
816. BIRTH REGISTRATION: The registered lay midwife must complete a birth certificate and file it with the local registrar within ten days of the birth.
817. SANITATION: The registered lay midwife shall maintain all equipment used in the practice of midwifery in an aseptically clean manner and in working order.
818. RECORDS: The registered lay midwife shall maintain records of each patient on forms approved by the Department. Inactive records shall be maintained no less than ten years.
819. ANTEPARTUM: The registered lay midwife shall refer for medical evaluation and/or care any woman who during the antepartum period:
- 819.01. Develops a blood pressure of 140/90 or an increase of 30 mm Hg systolic or 15 mm Hg diastolic over her normal blood pressure.
 - 819.02. Develops edema of the face and hands.
 - 819.03. Develops severe, persistent headaches, epigastric pain or visual disturbances.
 - 819.04. Does not gain 14 pounds by 30 weeks gestation or at least 4 pounds a month in the last trimester or gains more than 6 pounds in two weeks in any trimester.
 - 819.05. Develops glucosuria or proteinuria.

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- 819.06. Has symptoms of vaginitis.
 - 819.07. Has symptoms of urinary tract infection.
 - 819.08. Has vaginal bleeding before os.
 - 819.09. Has premature rupture of membranes.
 - 819.10. Noted decrease in or cessation of fetal movement.
 - 819.11. Has inappropriate gestational size.
 - 819.12. Has demonstrated anemia by blood test (hematocrit less than 30%).
 - 819.13. Has a fever of 100.4 degrees F. or 38 degrees C for 24 hours.
 - 819.14. Has effacement and/or dilatation of the cervix prior to 36 weeks gestation.
 - 819.15. Has polyhydramnios or oligohydramnios.
 - 819.16. Has excessive vomiting or continued vomiting after 24 weeks gestation.
 - 819.17. Is found to be Rh negative.
 - 819.18. Has severe, protruding varicose veins of extremities or vulva.
 - 819.19. Is 36 years of age or older.
820. INTRAPARTUM: The registered lay midwife shall refer for medical evaluation and/or care any woman who during the intrapartum period:
- 820.01. Develops a blood pressure of 140/90 or an increase of 30 mm Hg systolic or 15 mm Hg diastolic over her normal blood pressure.
 - 820.02. Develops severe headache, epigastric pain or visual disturbance.
 - 820.03. Develops proteinuria.
 - 820.04. Develops a fever over 100.4 degrees F or 38 degrees C.
 - 820.05. Develops respiratory distress.

- 820.06. Has fetal heart tones below 100 or above 160 beats per minute between or during contractions, or a fetal heart rate that is irregular.
- 820.07. Has ruptured membranes without onset of labor after 12 hours.
- 820.08. Has bleeding prior to delivery.
- 820.09. Has meconium stained amniotic fluid.
- 820.10. Has a presenting part other than a vertex.
- 820.11. Does not progress in effacement, dilatation or station after 2 hours in active labor (or 1 hour if distance to hospital is greater than 60 miles).
- 820.12. Does not show continued progress to delivery after 2 hours of second stage labor (or 1 hour if distance to hospital is greater than 60 miles).
- 820.13. Does not deliver the placenta within 2 hours if there is no bleeding and the fundus is firm (or 1 hour if distance to hospital is greater than 60 miles).
- 820.14. Has a partially separated placenta with bleeding or has a blood pressure below 100 systolic or a pulse rate over 100 beats per minute or is weak or dizzy.
- 820.15. Bleeds more than 500 cc (2 cups) with or after the delivery of the placenta.
- 820.16. Has retained placental fragments or membranes.
- 820.17. Desires medical consultation or transfer.
- 821. POSTPARTUM: The registered lay midwife shall refer for medical evaluation and/or care any woman who during the postpartum period:
 - 821.01. Has a second, third or fourth degree laceration.
 - 821.02. Has uterine atony.
 - 821.03. Bleeds in an amount greater than normal lochial flow.

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STATE COMMISSION OF
NURSING ARCHIVES

- 821.04. Does not void within 6 hours of birth.
- 821.05. Develops a fever greater than 100⁴⁰F. 38⁰C on any 2 of the first 10 days postpartum excluding the first 24 hours.
- 821.06. Develops foul smelling lochia.
- 822. NEWBORN PROBLEMS: The registered lay midwife will refer for medical evaluation and/or care any infant who:
 - 822.01. Has an Apgar score of 7 or less at 5 minutes.
 - 822.02. Has any obvious anomaly.
 - 822.03. Develops grunting respirations, retractions or cyanosis.
 - 822.04. Has cardiac irregularities
 - 822.05. Has a pale, cyanotic or grey color.
 - 822.06. Has an abnormal cry.
 - 822.07. Weighs less than 5 1/2 pounds or 2500 grams or weighs more than 9 pounds or 4100 grams.
 - 822.08. Shows signs of prematurity, dysmaturity or postmaturity.
 - 822.09. Has meconium staining.
 - 822.10. Does not urinate or pass meconium in the first 12 hours after birth.
 - 822.11. Is lethargic or does not nurse well.
 - 822.12. Has edema.
 - 822.13. Appears weak or flaccid, has abnormal feces or appears not to be normal in any other respect.

PROHIBITION AND LIMITATION IN THE PRACTICE OF LAY MIDWIFERY

- 900. UNAPPROVED PRACTICE: The registered lay midwife shall not knowingly accept responsibility for the prenatal or intrapartum care of a woman who:

- 900.01. Has had a previous Cesarean section or other known uterine surgery such as hysterotomy or myomectomy.
- 900.02. Has a history of difficult to control hemorrhage with previous deliveries.
- 900.03. Has a history of low birth weight infants (2500 grams or less), stillbirths or neonatal deaths.
- 900.04. Has a history of birth injury to mother or infant in any previous delivery.
- 900.05. Has a history of third trimester bleeding.
- 900.06. Has a history of thrombophlebitis or pulmonary embolism.
- 900.07. Has diabetes, hypertension, Rh disease with positive titer, active tuberculosis, active syphilis, active gonorrhea, epilepsy, hepatitis, heart disease or kidney disease.
- 900.08. Has genital herpes simplex in the first trimester or in the last four weeks of pregnancy.
- 900.09. Has a contracted pelvis.
- 900.10. Has severe psychiatric illness or a history of psychiatric illness in the 6 month per 1 prior to pregnancy.
- 900.11. Is addicted to narcotics or other drugs.
- 900.12. Ingests more than 2 ounces of alcohol or 2 beers a day on a regular basis or participates in binge drinking.
- 900.13. Has a multiple gestation.
- 900.14. Has a fetus of less than 37 weeks gestation at the onset of labor.
- 900.15. Has a gestation beyond 42 weeks by dates.
- 900.16. Has a fetus in any presentation other than vertex at the onset of labor.

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- 900.17. Is a primigravida with an unengaged fetal head at the onset of labor, or any woman who has rupture of membranes with unengaged fetal head, with or without labor.
- 900.18. Has a fetus with suspected or diagnosed congenital anomalies that may require immediate medical intervention.
- 900.19. Has pre-eclampsia.
- 900.20. Has a parity greater than 5.
- 900.21. Is 17 years of age or younger.
- 900.22. Smokes 20 cigarettes or more, per day, and is not likely to cease in pregnancy.
- 901. EXAMINATION IN LABOR: The registered lay midwife will not perform any vaginal examinations on a woman with ruptured membranes and no labor, other than an initial examination to be certain there is no prolapsed cord. Once active labor is assuredly in progress, exams may be made as necessary.
- 902. OPERATIVE PROCEDURES: The registered lay midwife will not perform any operative procedure other than: clamping and cutting the umbilical cord; repair of a first or second degree laceration.
- 903. MEDICATIONS: The registered lay midwife will not administer any drugs, medications or herbs except when specifically ordered to do so by a physician and when administering medication in accordance with Regulations Governing the Prevention of Infant Blindness.
- 904. ARTIFICIAL MEANS: The registered lay midwife will not use any artificial, forcible or mechanical means to assist the birth.
- 905. CORRECTION OF PRESENTATION: The registered lay midwife will not attempt to correct fetal presentations by external or internal version.

SUPERVISION BY DIVISION

1000. ADVISORY GROUP: The Division shall appoint a Lay Midwifery Advisory Group which will assist in the development, practice and problems of lay midwifery, assist Division staff in the development of examinations (written and oral). The Lay Midwifery Advisory Group will be composed of five (5) members:

1000.01. One physician who must be active in perinatal care;

1000.02. One certified nurse midwife;

1000.03. Two regularly registered lay midwives;

1000.04. One member at large.

The Lay Midwifery Advisory Group will meet at least biennially to evaluate practice of lay midwifery as reflected in the semi-annual reports during the time that the program is becoming established.

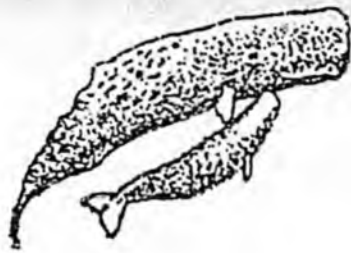
1001. QUARTERLY REPORTS: The registered lay midwife shall submit quarterly to the Health Services Division, Health and Environment Department, a summary report in a form prescribed by the Division. This report must be submitted within 30 days of the end of the quarterly period. Individually identifying information shall not be required.

1002. MORTALITY: IMMEDIATE REPORTING: The registered lay midwife must report within 48 hours to the Health Services Division any fetal, neonatal or maternal mortality in patients she has cared for or any major morbidity as outlined in the section Prohibitions and Limitations of Practice.

1003. FORMS SUPPLIED: The Department will send to each registered lay midwife an ample supply of quarterly reports one month prior to the beginning of each three month period. The Division will also furnish any other forms required.

1004. STATISTICS: The Department will compile annual lay midwifery statistics and make them available to registered lay midwives and other interested groups or persons.

1005. PREVENTION OF INFANT BLINDNESS: The Department will provide necessary supplies for prophylactic treatment of infant eyes as required by these regulations.
1006. These regulations supersede the Regulations Governing the Practice of Midwifery adopted by the State Board of Public Health, May 4, 1944, and the previous version of the same Regulations, No. HED-80-3 (HSD) filed on February 5, 1980.



March 15, 1982

Dear legislature,

I am responding to Senate Bill 747 "An Act Relating to midwifery." I've in the past have sent in my suggested revisions for HB11 and see the changes reflected in SB 747. Although there are points I'm not comfortable with and am unclear about, I feel it's a bill that midwives and families can benefit from.

As a laymidwife, I have met much resistance and little support from the established medical system. I've been criticized for not having costly medical tools (I do not charge), lack of knowledge surrounding medical procedures and the skills to use them (which if I did perform such a medical procedure I face practicing medicine without license). Yet, it is these very people who aren't open enough to share and teach these skills and knowledge but make the charges if performed. I've been personally been pressured, blacklisted and verbally threatened to discontinue working with folks who seek me out. These folks do not want to birth with the medical system due to many reasons. Some reasons being cost, frontier spirit, non intervention, control and responsibility in decisions, comfortableness of their home environment, dislike of doctors and/or hospitals, feeling pregnancy and birth is a normal physiological process and not a medical procedure or just their philosophy. By trying to eliminate laymidwives

will not stop home births. But enlarges the all ready existing gap for communication, screening for problems and medical availability when needed between care givers and families.

This gap could be lessened with this bill and all efforts should at least be made to not enlarge the gap. The established medical system is valuable and has its place, but need it control other forms of workable health care systems and philosophies? Isn't our constitution designed to protect its citizens from such an anarchy?

Because of the choices available for the birth of my next child, we are having to seriously consider leaving our home and state. We are not comfortable with asking a midwife to place herself in a legal vulnerable position, doing the birth by ourselves nor going to the practitioners that have been out right hostile to me.

I plea as a mother who has birthed at home, a worker who has worked labor/birth in hospitals, a woman who has been called on to stand by birthing families and a person who sincerely wants to be a credible helping citizen, for you to listen and provide for your people. I urge you to support and pass SB777.

Most Caringly,

Kathleen Stier

Box 1136

Homer, Alaska 99603

March 16, 1982

Dear Vic

Thank you for your letter, it was informative and appreciated. I have been encouraging my friends and clients to voice themselves about SB 747. I will be at the March 25 tele conference. I have some questions about the apprenticeship I hope to have explained then. Enclosed are some copies of studies I thought you might find helpful. I would appreciate if you would be sure that copies of them are sent to supportive and key persons. Also I enclosed a booklet that I thought you may find interesting, if not, amusing.

I understand the Alaska Hospital Ass. has a lobbyist. How much pull and effect does this have? Do we (who have had to function underground with little or no pay) realistically have a chance for the bill to pass against a established organization with \$ behind them?

Thanks again, I would appreciate ~~it~~ being kept posted. I seem to be the contact for this area and do share the news.

Warmly,

Kathleen Stier

We were involved in all aspects of the birth and post natal care from cutting the cord to checking apgar score, to cleaning baby up, to nursing our little girl right after birth. It was wonderful.

We realize that not all deliveries are without complication, but most potential problems can be detected before the actual birth which would put those people in a high risk category for home births, and lay midwives that we know will not deliver for anyone who is a high risk. They want what is best for our children too.

was an impersonal experience for everyone but us. After the delivery our son was taken away from us for a couple of hours so he could be cleaned up, etc.

Our home birth was also a successful delivery but with the help of a understanding lay midwife and a well read husband involved. The experience was much more enjoyable. The lights were dim, low playing music, comfortable bed that I was used to, good friends to help and to take pictures, and just an all round relaxed atmosphere.

right to continue doing so
as long as people like us
want and need them to
deliver our children in
the place we feel most
comfortable, our homes.

We have had two child-
ren. One with doctors,
nurses and the hospital;
the other at home with the
help of a lay midwife.
The hospital birth went
very well as far as a
successful delivery, but
there were interruptions
from nurses and doctors,
other women in labor,
some screaming, everyone
in a hurry; all this
was very disturbing to
us and made us feel
that the birth of our child

We are now expecting
our third child and are
definitely considering
another home birth. We
hope that lay-midwifery
will still be an option
available to us so that
we will have the choice
if we so choose.

Thank you for listening
to our opinions.

Susan L. Connor
+ Charles B. Connor

HOUSE RESEARCH AGENCY
Pouch Y - State Capitol
Juneau, Alaska 99811
465-3991

TO: Representative Joe McKinnon January 14, 1980

FROM: Christine Johnson, Research Analyst CEJ
House Research Agency

THROUGH: Duncan L. Read, Director
House Research Agency

SUBJECT: Comparative Analysis of Midwife Statutes
Research Request No. 10

Enclosed please find statutes from twenty-one states pertaining to the licensing of midwives. We have included several pages of charts which indicate by state the types of midwives (ie., lay, professional or nurse-midwives) who are licensed to practice, the range of their responsibilities, and any special provisions the statutes contain. The chart can be used as an index reference for the statutes, all of which are attached in full.

If you need further information on this or any other matter, please do not hesitate to contact us.

CJ/bf
Encl.s

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

ALABAMA

(Professions and Businesses 4.34-19-1-.34-19-10)

| STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES | | ALABAMA (Professions and Businesses 4.34-19-1-.34-19-10) |
|--|------------------------------|---|
| <p><u>NURSE-MIDWIFE</u></p> <p><u>Definition:</u></p> <p>Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p> | Requirements | Licensed registered nurse; certificate from school for nurse-midwives. |
| | Limitations on Practice | Cases of normal childbirth; physician's supervision necessary. |
| | Special Statutory Provisions | All deliveries must be planned to take place in hospital. |
| <p><u>PROFESSIONAL MIDWIFE</u></p> <p><u>Definition:</u></p> <p>An individual who has received formal professional training as a midwife.</p> | Requirements | |
| | Limitations on Practice | |
| | Special Statutory Provisions | |
| <p><u>LAY MIDWIFE</u></p> <p><u>Definition:</u></p> <p>An individual who practices as a midwife but has not received formal professional training.</p> | Requirements | |
| | Limitations on Practice | Lay midwives holding health department permits may continue to practice until permits are revoked by Board of Health. |
| | Special Statutory Provisions | |

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

CALIFORNIA

(Business and Professional Codes 2.5.2746 - 2.5.2746.8; 12.5.2350-12.5.2359)

| STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES | | CALIFORNIA (Business and Professional Codes 2.5.2746 - 2.5.2746.8; 12.5.2350-12.5.2359) |
|--|------------------------------|---|
| <p><u>NURSE-MIDWIFE</u></p> <p><u>Definition:</u></p> <p>Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p> | Requirements | |
| | Limitations on Practice | Practice supervised by physician or surgeon (physician's presence not required); case of normal childbirth. Authorized to provide family-planning care. Shall not use instruments, or artificial, forcible, or mechanical means to assist childbirth, nor perform version; shall refer complicated cases to physician. Shall not perform abortions. |
| | Special Statutory Provisions | Requirements for censure are left up to appropriate boards and committees. In general, California's statutes establish the confines of the practice. |
| <p><u>PROFESSIONAL MIDWIFE</u></p> <p><u>Definition:</u></p> <p>An individual who has received formal professional training as a midwife.</p> | Requirements | |
| | Limitations on Practice | |
| | Special Statutory Provisions | |
| <p><u>LAY MIDWIFE</u></p> <p><u>Definition:</u></p> <p>An individual who practices as a midwife but has not received formal professional training.</p> | Requirements | |
| | Limitations on Practice | |
| | Special Statutory Provisions | |

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

CONNECTICUT

(377.20-75)

| STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES | | CONNECTICUT (377.20-75) |
|--|------------------------------|--|
| <p><u>NURSE-MIDWIFE</u></p> <p><u>Definition:</u></p> <p>Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p> | Requirements | |
| | Limitations on Practice | |
| | Special Statutory Provisions | |
| <p><u>PROFESSIONAL MIDWIFE</u></p> <p><u>Definition:</u></p> <p>An individual who has received formal professional training as a midwife.</p> | Requirements | Graduate of school of midwifery. |
| | Limitations on Practice | Cases of normal labor (uncomplicated vertex or head presentation). Shall not use drugs, instruments, nor perform version or attempt to remove adherent placenta. Shall not attend woman in labor until after seventh month of gestation. |
| | Special Statutory Provisions | Examination required for licensing. |
| <p><u>LAY MIDWIFE</u></p> <p><u>Definition:</u></p> <p>An individual who practices as a midwife but has not received formal professional training.</p> | Requirements | |
| | Limitations on Practice | |
| | Special Statutory Provisions | |

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

FLORIDA

(30.485.011 - 30.485.091)

| STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES | | FLORIDA (30.485.011 - 30.485.091) |
|---|------------------------------|---|
| <p><u>NURSE-MIDWIFE</u></p> <p>Definition:</p> <p>Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p> | Requirements | |
| | Limitations on Practice | |
| | Special Statutory Provisions | |
| <p><u>PROFESSIONAL MIDWIFE</u></p> <p>Definition:</p> <p>An individual who has received formal professional training as a midwife.</p> | Requirements | Diploma from school for midwives; sponsorship by two practicing physicians; ability to read manual intelligently and write legibly (this may be waived). |
| | Limitations on Practice | Cases of normal labor; shall not use drugs, instruments, nor assist labor in any artificial, forcible, or mechanical manner, nor attempt to remove adherent placenta. Shall not use poisonous drug or herb medicine, nor attempt treatment of disease when attendance of physician cannot be secured. |
| | Special Statutory Provisions | |
| <p><u>LAY MIDWIFE</u></p> <p>Definition:</p> <p>An individual who practices as a midwife but has not received formal professional training.</p> | Requirements | Attendance, under the supervision of a physician, at not less than fifteen cases of labor and the care of fifteen or more mothers and newborns for periods of at least ten days each; sponsorship by two physicians; ability to read manual intelligently and write legibly (this may be waived). |
| | Limitations on Practice | |
| | Special Statutory Provisions | |

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

INDIANA

(25-22-1-5, 22-22-1-6; Admin. Rules (25-22.5-5-5)-1, (25-22.5-5-5)-2)

| STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES | | INDIANA |
|--|------------------------------|--|
| <p><u>NURSE-MIDWIFE</u></p> <p><u>Definition:</u></p> <p>Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p> | Requirements | |
| | Limitations on Practice | |
| | Special Statutory Provisions | |
| <p><u>PROFESSIONAL MIDWIFE</u></p> <p><u>Definition:</u></p> <p>An individual who has received formal professional training as a midwife.</p> | Requirements | Diploma from school of midwifery which has proper equipment to teach anatomy, physiology, hygiene, anticepsis, neurology, toxicology, and the proper management of labor; high school education; ability to read and write the English language* *There are few schools in this country which train midwives who are not nurses. Since many professional midwives were educated at foreign institutions, some states feel it necessary to require proficiency in English. |
| | Limitations on Practice | |
| | Special Statutory Provisions | (Statutes pertaining to midwifery in Indiana date to the late 1800's. Midwifery in the state is presently controlled by administrative code. Both the statutes and codes have been included.) Examination required for licensing. Gratuitous services in an emergency not prohibited by act, nor does it restrict licensed physicians. |
| <p><u>LAY MIDWIFE</u></p> <p><u>Definition:</u></p> <p>An individual who practices as a midwife but has not received formal professional training.</p> | Requirements | |
| | Limitations on Practice | |
| | Special Statutory Provisions | |

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

MARYLAND

(Art. 43.82-94)

| STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES | | MARYLAND (Art. 43.82-94) |
|--|------------------------------|---|
| <p><u>NURSE-MIDWIFE</u></p> <p><u>Definition:</u></p> <p>Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p> | Requirements | Certified by American College of Nurse-Midwives as a nurse-midwife. |
| | Limitations on Practice | Normal cases of pregnancy; cannot practice medicine or prescribe drugs. Shall not induce labor or produce abortion. |
| | Special Statutory Provisions | Person who is not licensed midwife may practice under the personal and direct supervision of a physician. Subtitle does not restrict physician or person volunteering service in an emergency. |
| <p><u>PROFESSIONAL MIDWIFE</u></p> <p><u>Definition:</u></p> <p>An individual who has received formal professional training as a midwife.</p> | Requirements | |
| | Limitations on Practice | |
| | Special Statutory Provisions | |
| <p><u>LAY MIDWIFE</u></p> <p><u>Definition:</u></p> <p>An individual who practices as a midwife but has not received formal professional training.</p> | Requirements | |
| | Limitations on Practice | |
| | Special Statutory Provisions | Maryland midwifery laws updated 1970. Previous laws licensed midwives determined qualified by two practicing physicians. (These statutes have been included). |

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

MINNESOTA

(148.30 - 148.32)

| STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES | | MINNESOTA (148.30 - 148.32) |
|--|------------------------------|--|
| <p><u>NURSE-MIDWIFE</u></p> <p><u>Definition:</u></p> <p>Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p> | Requirements | |
| | Limitations on Practice | |
| | Special Statutory Provisions | |
| <p><u>PROFESSIONAL MIDWIFE</u></p> <p><u>Definition:</u></p> <p>An individual who has received formal professional training as a midwife.</p> | Requirements | Diploma from a school of midwifery. |
| | Limitations on Practice | |
| | Special Statutory Provisions | |
| <p><u>LAY MIDWIFE</u></p> <p><u>Definition:</u></p> <p>An individual who practices as a midwife but has not received formal professional training.</p> | Requirements | Consent of seven members of the State Board of Medical Examiners given after examination of candidate. |
| | Limitations on Practice | |
| | Special Statutory Provisions | |

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

MONTANA
(66-1246)

| | | |
|--|------------------------------|---|
| <p><u>NURSE-MIDWIFE</u></p> <p><u>Definition:</u></p> <p>Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p> | Requirements | Certificate in nurse-midwifery from the American College of Nurse-Midwives. |
| | Limitations on Practice | |
| | Special Statutory Provisions | |
| <p><u>PROFESSIONAL MIDWIFE</u></p> <p><u>Definition:</u></p> <p>An individual who has received formal professional training as a midwife.</p> | Requirements | |
| | Limitations on Practice | |
| | Special Statutory Provisions | |
| <p><u>LAY MIDWIFE</u></p> <p><u>Definition:</u></p> <p>An individual who practices as a midwife but has not received formal professional training.</p> | Requirements | |
| | Limitations on Practice | |
| | Special Statutory Provisions | |

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

NEW JERSEY

(45:10)

| STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES | | NEW JERSEY (45:10) |
|--|------------------------------|---|
| <p><u>NURSE-MIDWIFE</u></p> <p><u>Definition:</u></p> <p>Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p> | Requirements | |
| | Limitations on Practice | |
| | Special Statutory Provisions | |
| <p><u>PROFESSIONAL MIDWIFE</u></p> <p><u>Definition:</u></p> <p>An individual who has received formal professional training as a midwife.</p> | Requirements | Certificate from school of midwifery, or maternity hospital granted after 1800 hours of instruction in not less than nine months. Certificate from foreign school of midwifery of equal requirements. Endorsement by physician. |
| | Limitations on Practice | Shall not perform criminal abortion. Normal labor cases. only. |
| | Special Statutory Provisions | Examination required. Topics covered by examination specifically laid out by statute. Chapter does not restrict physician nor gratuitous service in an emergency. New Jersey midwifery laws similar to Washington's. |
| <p><u>LAY MIDWIFE</u></p> <p><u>Definition:</u></p> <p>An individual who practices as a midwife but has not received formal professional training.</p> | Requirements | |
| | Limitations on Practice | |
| | Special Statutory Provisions | |

STATUTORY PROVISIONS PER-
TAINING TO LICENSING
OF MIDWIVES

OHIO

(4731.30-4731.34)

| | | |
|--|------------------------------|---|
| <p><u>NURSE-MIDWIFE</u></p> <p><u>Definition:</u></p> <p>Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p> | Requirements | Diploma from college for nurse-midwives |
| | Limitations on Practice | Practice under direction and supervision of physician. Shall not perform version, treat breech or face presentation, use instruments, or treat abnormal condition, except in emergencies. |
| | Special Statutory Provisions | Examination may be required. |
| <p><u>PROFESSIONAL MIDWIFE</u></p> <p><u>Definition:</u></p> <p>An individual who has received formal professional training as a midwife.</p> | Requirements | |
| | Limitations on Practice | |
| | Special Statutory Provisions | |
| <p><u>LAY MIDWIFE</u></p> <p><u>Definition:</u></p> <p>An individual who practices as a midwife but has not received formal professional training.</p> | Requirements | |
| | Limitations on Practice | |
| | Special Statutory Provisions | |

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

UTAH

(58-44-1 - 58-44-11)

| | | |
|--|------------------------------|---|
| <p><u>NURSE-MIDWIFE</u></p> <p><u>Definition:</u></p> <p>Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p> | Requirements | Completed approved certified nurse-midwifery education program. |
| | Limitations on Practice | Under this act, may also provide normal gynecological services. |
| | Special Statutory Provisions | Establishes committee to supervise practice of nurse-midwifery. Examination required. Act does not affect rights of parents to deliver their baby, where, when, how and with who they choose regardless of certification. |
| <p><u>PROFESSIONAL MIDWIFE</u></p> <p><u>Definition:</u></p> <p>An individual who has received formal professional training as a midwife.</p> | Requirements | |
| | Limitations on Practice | |
| | Special Statutory Provisions | |
| <p><u>LAY MIDWIFE</u></p> <p><u>Definition:</u></p> <p>An individual who practices as a midwife but has not received formal professional training.</p> | Requirements | |
| | Limitations on Practice | |
| | Special Statutory Provisions | |

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

WASHINGTON

(18.50.090 - 18.50.110)

| STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES | | WASHINGTON (18.50.090 - 18.50.110) |
|--|------------------------------|---|
| <p><u>NURSE-MIDWIFE</u></p> <p><u>Definition:</u></p> <p>Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p> | Requirements | |
| | Limitations on Practice | |
| | Special Statutory Provisions | |
| <p><u>PROFESSIONAL MIDWIFE</u></p> <p><u>Definition:</u></p> <p>An individual who has received formal professional training as a midwife.</p> | Requirements | Diploma from legally incorporated school on midwifery in good standing, granted after at least 2 courses of instruction of at least seven months each in different calendar years. Diploma from foreign institution on midwifery of equal requirements. |
| | Limitations on Practice | Shall not prescribe any drugs or medicine except some household remedy. |
| | Special Statutory Provisions | Examination required. Topics covered by examination specifically laid out by statute. Gratuitous service not prohibited by chapter. Washington's midwifery laws similar to New Jersey's. |
| <p><u>LAY MIDWIFE</u></p> <p><u>Definition:</u></p> <p>An individual who practices as a midwife but has not received formal professional training.</p> | Requirements | |
| | Limitations on Practice | |
| | Special Statutory Provisions | |

STATUTORY PROVISIONS PERTAINING TO LICENSING OF MIDWIVES

WEST VIRGINIA

(30-15-1 -30-15-8)

| | | |
|--|------------------------------|---|
| | | |
| <p><u>NURSE-MIDWIFE</u></p> <p><u>Definition:</u></p> <p>Registered nurse who has expanded his/her practice to the care of mothers and babies through the maternity cycle.</p> | Requirements | Graduate of school of midwifery; certified by American College of Nurse-Midwives. |
| | Limitations on Practice | Practice under the supervision of or in association with physician engaged in family practice or specialized field of gynecology or obstetrics. |
| | Special Statutory Provisions | Persons holding licenses issued before current laws enacted may continue to practice until expiration of licenses without privilege of renewal. |
| <p><u>PROFESSIONAL MIDWIFE</u></p> <p><u>Definition:</u></p> <p>An individual who has received formal professional training as a midwife.</p> | Requirements | |
| | Limitations on Practice | |
| | Special Statutory Provisions | |
| <p><u>LAY MIDWIFE</u></p> <p><u>Definition:</u></p> <p>An individual who practices as a midwife but has not received formal professional training.</p> | Requirements | |
| | Limitations on Practice | |
| | Special Statutory Provisions | |

TO: Senate HESS Committee members
FROM: Nancy Deitrick
RE: Video Teleconference

The video teleconference for SB 747 "An act relating to Midwifery" on March 25, 3:00 p.m. to 5:00 p.m. is in room 423 of the Capitol building.

Following the video portion of the teleconference, we will be switching to audio for all sites.

A video teleconference is completely scheduled before the conference starts, and there are many people wishing to speak. Testimony has been limited to three minutes, and for this reason members are being requested to limit questions to participants as much as possible.

The conference will open with Charlie Parr introducing the committee members and giving a brief summary of the bill. We will then go to Fairbanks(35 min.), Sitka(35 min.) and Anchorage(45+ min.). Sitka is set up only to receive video, so all sites will be viewing the committee during their testimony. Fairbanks and Anchorage will be viewing the committee during their testimony, with other sites seeing the person testifying. The name of the person testifying will be on the television screen.

Bethel had to be dropped from the video portion because of technical problems.

DO NOT wear a white shirt!



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-3991

March 27, 1981

MEMORANDUM

TO: Representative Tony Vaska

FROM: Leslie Longenbaugh LL
Research Staff

RE: Lay Midwifery in Oregon
Research Request Number 81-89

You have asked that we investigate the history and consequences of the Oregon Attorney General's opinion of June 17, 1977 regarding lay midwifery. Specifically, you asked about 1) the legal rationale used by the Attorney General in his opinion; 2) how the legislators who oppose lay midwifery happened to forego the opportunity to legislate against the practice; 3) whether Oregon has been held liable for health problems or deaths resulting from lay midwifery; and 4) whether Oregon keeps a register or other list of lay midwives.

Linda Vaska asked that we relay the information to your office in installments, if necessary. This memorandum presents the preliminary results of our research.

We spoke with Marianne Remy, of the Oregon Department of Health¹, who was able to answer your questions as follows.

1. What was the legal rationale used by the Attorney General's office in his opinion?

Oregon law apparently provides that only those medical procedures defined as involving a "disease state" require the presence of a physician or registered nurse. Childbirth is not defined by the Attorney General as a "disease state," or as an intrusive and surgical procedure, and therefore is not a procedure that requires the attendance of a licensed medical practitioner. The Attorney General's opinion prohibits lay midwives from administering medication and from performing episiotomies.² In the case of an emergency during a delivery, a lay midwife either calls

¹Marianne Remy, Oregon State Department of Health, Portland, Oregon; phone: (503) 229-5806.

²According to Ms. Remy, lay midwives rarely violate these prohibitions, in large part because of the "nonintrusive" philosophy that informs their work.

Representative Vaska
March 27, 1981
Page 3

In Alaska, David Spence is the Director of the Family Health Section of the Division of Public Health in the Department of Health and Social Services.³ He might be able to give more information on lay midwifery, not only in Alaska and Oregon but for other states as well.

If you would like us to analyse the opinion in light of Oregon and Alaska law, please call on us.

LL/dp



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-3991

March 31, 1981

MEMORANDUM

TO: Representative Tony Vaska

FROM: Leslie Longenbaugh *LL*
Research Staff

RE: Lay Midwifery in Oregon, Additional Information
Research Request Number 81-89

In our memorandum to you of March 27, we mentioned that we would be contacting the author of the Oregon Attorney General's opinion on lay midwifery. We spoke this morning with Arnie Silver¹ of the Oregon Attorney General's office, who offered a somewhat different perspective on lay midwifery in that state.

Mr. Silver described his legal approach in writing the opinion as one which employed not only the "disease state" criterion alluded to by Ms. Remy (see our March 27 memorandum), but also an old Oregon statute that allows a midwife to sign a birth certificate. He interpreted this law to mean that the Oregon Legislature had intended to allow lay midwives to deliver babies.²

Mr. Silver is of the opinion that strong opposition to lay midwifery does not exist in Oregon, except among members of the medical community. He feels that, owing to Oregon's strong "naturalistic" movement, many people support the notion of "natural" childbirth performed at home under the guidance of a lay midwife.

In answer to your question concerning the state's legal liability, Mr. Silver believes that his state has no legal responsibility whatsoever in the practices of lay midwives, as Oregon does not participate in any licensing or training.

The copy of the Oregon opinion sent to us by Ms. Remy has not yet arrived; as soon as it does, we will forward a copy to your office.

If we can be of further assistance, please call on us.

¹Arnie Silver, Assistant Attorney General, Portland Division; phone: (503) 229-5725.

²Mr. Silver mentioned that the opinion was requested by the Oregon Board of Nursing, which wanted to know whether lay midwives were practicing nursing, and therefore would come within the purview of Oregon laws governing nursing.

CORRECTION

CORRECTION



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-3991

March 27, 1981

MEMORANDUM

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Representative Vaska
March 27, 1981
Page 2

a local physician or transports the mother and child to the emergency room of a local hospital. The question of whether lay midwives may cut the cord of an infant has not been addressed, either in the opinion or in the enforcement of the opinion's prohibition against surgical procedures.

2. Why have Oregon legislators who oppose lay midwifery not attempted to pass legislation to restrict or limit the practice?

Ms. Remy reports that the members of the medical community and legislators who oppose lay midwifery and home childbirth were not aware of the extent of lay midwifery that was practiced in Oregon at the time of the Attorney General's opinion. Now that lay midwives have formed associations and have become quite visible in the state, such organizations as the Oregon Medical Association have begun to press for legislation to restrict attendance at a childbirth to licensed physicians and nurses. In fact, such a bill apparently has been introduced during the current session of the Oregon Legislature.

3. Has Oregon been held liable for illness or death attributable to the practice of lay midwifery?

Ms. Remy is not aware of any suits charging that the state is liable in cases of complications resulting from childbirth through lay midwifery. She indicated that this question could be better answered by the Attorney General's office.

4. Does Oregon keep a register of lay midwives?

There is no list of midwives compiled by the state.

The member of the Oregon Attorney General's staff who wrote the 1977 opinion will not be in the office until Monday, March 30; we will call him then, and send you additional information based on this conversation. Ms. Remy is sending us a copy of the Attorney General's opinion.

The Oregon Public Health Association has recently formed a resource committee to study the issue of alternative childbirth; Ms. Remy is a member of this new committee. The committee plans to study the outcomes of several types of childbirth, among them lay midwifery.

³David Spence, Director, Family Health Section, Division of Public Health, Department of Health and Social Services; phone: 465-3100.

Representative Vaska
March 27, 1981
Page 3

In Alaska, David Spence is the Director of the Family Health Section of the Division of Public Health in the Department of Health and Social Services.³ He might be able to give more information on lay midwifery, not only in Alaska and Oregon but for other states as well.

If you would like us to analyse the opinion in light of Oregon and Alaska law, please call on us.

LL/dp



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-3991

March 31, 1981

MEMORANDUM

TO: Representative Tony Vaska

FROM: Leslie Longenbaugh *LL*
Research Staff

RE: Lay Midwifery in Oregon, Additional Information
Research Request Number 81-89

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Mr. Silver described his legal approach in writing the opinion as one which employed not only the "disease state" criterion alluded to by Ms. Remy (see our March 27 memorandum), but also an old Oregon statute that allows a midwife to sign a birth certificate. He interpreted this law to mean that the Oregon Legislature had intended to allow lay midwives to deliver babies.²

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If we can be of further assistance, please call on us.

¹Arnie Silver, Assistant Attorney General, Portland Division; phone: (503) 229-5725.

²Mr. Silver mentioned that the opinion was requested by the Oregon Board of Nursing, which wanted to know whether lay midwives were practicing nursing, and therefore would come within the purview of Oregon laws governing nursing.

March 3, 1982

To: Representative Pat Carney, Chair
House Finance Subcommittee

From: Representatives Brian Rogers
and Tony Vaska

Prepared

By: Ginger Baim, Aide to
Senator Vic Fischer

Re: CS SS House Bill 11 and Senate Bill 747

During today's subcommittee work session on House Bill 11, the following issues should be considered:

1. Approximately 5% of all births in Alaska occur at home.
2. Most home-birth parents are covered by health care insurance but chose to pay a midwife "out-of-pocket" rather than use the services of a physician or a certified nurse midwife in a hospital setting covered by insurance.
3. Physicians and Certified Nurse Midwives (CNM) face suspension of licensure if they participate in a home-birth even though such practice is not in violation of the law in Alaska.
4. Most homebirth parents state they would chose an out-of-hospital birth with a midwife even if such a practice were in violation of the law.
5. The average cost of a "natural " and uncomplicated hospital birth attended by a physician or CNM, is \$2,000 and up. This fee covers both birth attendents and facility charge.
6. Some Alaskan hospitals and physicians average 20% C-sections. Consumer cost for this surgery is nearly double the average for a "natural" birth.
7. The average cost of childbirth at Alaska's only birthing center is \$1,500. Because the facility is not licensed, only the services of the CNM are covered by health care insurance, requiring out-of-pocket payment of nearly a \$1,000.
8. Average costs for the services of a "lay" midwife for a homebirth is less than \$500. This fee includes all pre and post natal care, laboratory costs, services of the midwife and, usually, an assistant or apprentice, during the acutal birth.
9. Statistically the incidence of complications, mortality, morbidity and risks to both infant and mother in a home birth attended by a midwife compare favorably with hospital births attended by a physician.
10. Current practice prevents licensed health care providers from attending home births and limits consumers in free choice of health care. Consumers currently have no mechanism for determining the competency

levels of midwives attending homebirths.

11. HB 11 and SB 747 provide a mechanism for voluntary licensing of midwives, regulation and supervision of the practice of midwifery through a self-regulating agency appointed by the Governor, a handle for consumers to determine the competency levels of their health care providers and a method of gathering information and statistics on the practice of midwifery and homebirths in Alaska.

12. According to a position paper from the Department of Health and Social Services on HB 11, prior to widespread availability of medical facilities, adequate transportation and professional providers, the Department promoted training for birth attendants in remote areas. Current revenue forecasts may require cuts in transportation, facilities and professional services by health care providers. This gives strong argument for reinstating licensing and training procedures for midwives to handle low-risk births in low-cost settings for consumers desiring these services.

13. The state has a legitimate interest in providing consumer protection and information. The state should not allow its laws to be used to promote a certain type of health care or to coerce or punish consumers exercising free choice in health care services.

CHARLIE PARR

ALASKA LEGISLATURE

S.R. Box 50399
Fairbanks, Alaska 99701
(907) 456-5029

Pouch V
Juneau, Alaska 99811
(907) 465-4907

March 2, 1982

Dr. William Bell
Box 194
Homer, Alaska 99603

Dear Dr. Bell:

Thank you for sending me copies of your letter of February 17 to Rep. Hugh Malone (lay midwives) and of February 19 to Sen. Mike Colletta (naturopaths).

Let me deal with the lay midwife issue first. Last year the Medical Board proposed a revision of the medical practice act which gave the Board authority to regulate lay midwives. My committee received almost 200 irate messages and letters opposing such regulation. When we held a teleconference on the bill there was another outcry. Dr. Jeffrey Partnow, President of the Board, was present and heard the opposition.

Witnesses said that: Childbirth is a natural process, not an illness; that they wanted their children born at home but could find no doctors willing to do home deliveries; that regulation of midwives was a power or money grab by doctors; and some claimed to have had trouble with the doctor/hospital birth and no trouble with the midwife/home birth.

As a result of the reaction the midwifery section was removed from the bill. Rep. Brian Rogers had a bill (HB 11) on midwifery in the House, and the Senate HESS Committee felt treating the subject separately would avoid jeopardizing the medical practice act. I can assure you that we will deal carefully with the subject.

The HESS Committee has now had a teleconference and a hearing on the naturopath bill. Nearly all testimony so far has been in favor. Witnesses have made the following points: They should have the right to be treated by naturopathic means if that is their preference, presently in order to exercise this right they must make an expensive trip to the lower 48, and finally they want naturopaths licensed to do only what those practitioners are trained and qualified to do.

Again, I think the Committee will move carefully. We are all laymen and we are all accustomed to listening to expert--but

conflicting--testimony. We will look at fairly recent statutes from other states and will attempt to learn what the experience has been in states which do license naturopaths.

Thank you again for your letters.

Sincerely,

Charles H. Parr

CHP:bk

cc: Senator Colletta
Representative Malone

FAIRBANKS INTERNAL MEDICINE

and

DIAGNOSTIC CENTER, INC.

1919 LATHROP STREET
FAIRBANKS, ALASKA 99701

(907) 452-4769

INTERNAL MEDICINE
WILLIAM H. DOOLITTLE, M.D. F.A.C.P.
JEFFREY A. PARTNOW, M.D.

INTERNAL MEDICINE, HEMATOLOGY & ONCOLOGY
J. MICHAEL CARROLL, M.D.

INTERNAL MEDICINE & AVIATION MEDICINE
DAVID S. GRAUMAN, M.D. F.A.C.P.

April 13, 1981

Senator Charles Parr
Pouch V
Juneau, AK 99811

Dear Senator Parr:

Please allow me to express thanks, both from the Medical Board and especially from myself personally, for the courtesy shown by your Committee in allowing me to testify on SB 237 last week. As I indicated on the plane, I was quite nervous about my appearance, having never done such a thing before, and the good auspices with which I was received were greatly appreciated.

Please also extend my thanks to Senators Stimson, Fischer, and Kelly.

The day after meeting with you, I spent a few hours with Doctor Spence at the Department of Public Health talking over the "obstetrical controversy". Should you or Senator Fischer decide to introduce separate statute concerning this, there are several points that I would like to make. As you are aware by now, I am speaking only as an individual who has devoted a fair amount of thought to the situation.

(1) As you correctly identified, there are two aspects to the problem. The first deals with home deliveries versus deliveries elsewhere, and I personally feel that this is probably a matter of personal preference and is certainly not anything that the State should legislate out of existence. Needless to say, I feel that there should be some medical screening somewhere along the line to minimize, insofar as possible, any predictable medical problems. The second aspect of the problem is that of layman providers. This is clearly a thornier issue.

(2) I feel strongly that all individuals providing obstetrical services on any sort of on-going basis ought to be "licensed" or "authorized". Inasmuch as there is no centralized certifying body, it will prove difficult to set up any kind of consistent procedure concerning training and qualifications. Those people without formal training who have had a good deal of prior experience, will be particularly difficult to evaluate.

(3) The testimony expressed at the hearing, while nearly unanimous and obviously quite impassioned and vociferous, clearly represents a minority point of view as cursory examination of Vital Statistic Records would bear out. In looking at the relevant statistics for Juneau in 1979, the last year for which records are available, it would appear that the instance of home delivery is between 3 and 5%. I am at a loss to explain the apathy shown by virtually all members of the majority viewpoint during the hearing.

*Copies members
of packets.*

(4) I feel that there must be some statutory (or regulatory) insistence on a mode of communication in the event of medical problems. I feel that there should be some formalized, prearranged communication mechanism rather than haphazard communication at the time that an emergency becomes apparent.

(5) For purposes of maintaining good Vital Statistics, there must be some insistence that a birth certificate be completed regardless of the location of birth. Dr. Spence indicates that perhaps 50% of home births are currently going unrecorded.

(6) Careful review of the relevant statutes and regulations dealing with nurse-midwives (advanced nurse practitioners) ought to be made to insure non-discrimination.

(7) In order to foster communication between the "medical establishment" and lay providers, there should be some specific statutory exemption from liability for physician or nurse midwife collaborators.

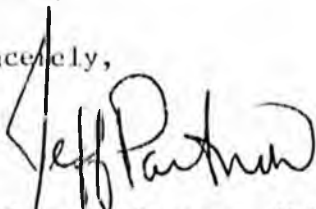
(8) Medical screening could be provided either by physicians or through the Department of Public Health.

(9) There is clearly a need for a massive public education campaign to outline the scope of potential services, high risk versus low risk pregnancies, etc.

(10) I continue to have strong personal feelings that the practice of medicine comprises a good deal more than treating "illnesses and conditions". The delivery of obstetrical care seems to me to be a part of the practice of medicine, and as such, is I feel a legitimate area of concern for the Medical Board. As I have stated, the Board is willing to tackle this difficult area if this is the desire of the Legislature. I would, however, be more than pleased to see someone else shoulder this particular burden.

At the risk of sounding like a stuck record, I would like to reiterate that I personally nor the Medical Board as a whole have any particular ax to grind in this matter other than the insurance of the provision insofar as feasible of adequate health care to the citizens of Alaska. I would be more than pleased to provide whatever input I can to you in any future deliberations concerning this matter.

Sincerely,



Jeffrey A. Partnow, M.D.
Chairman
State Medical Board

JAP/co

MSE 82-00010762 PRTY 1 02/26/82 18:28:47 ORIG: LM00 IN= 0011 OUT= 015
FROM: MARTIE/MATSU TO: JUNEAU INFORMATION . PAGE 000
TARGET: LJM2 SUBJ: P.O.M.

617

TO: SEN PARR, CHAIR SEN. HESS
FROM: JOE AND VIOLET REDINGTON
KNIK RD. BOX 5460
WASILLA 99687
(H) 376 5562, (W) 376 4256

RE: SB 617

WE ARE DEFINITELY IN FAVOR OF SB 617 FOR THE VOATIONAL AND AGRICULTURAL
TECHNICAL SCHOOL AT MAT SU COMMUNITY COLLEGE.

MR. CHARLIE PARR, CHAIRMAN
HEALTH, EDUCATION & SOCIAL SERVICES COMMITTEE
POUCH V
JUNEAU, ALASKA

*Bill
pl: not mt*

DEAR MR. PARR,

I WOULD LIKE TO ADVISE YOU OF MY STRONG SUPPORT OF S.B. #747- AN ACT
RELATING TO MIDWIFERY. WE NEED THE HELP OF LAY MIDWIVES IN THIS STATE.
COULD YOU PLEASE SET UP A TELE-CONFERENCE SO THAT PEOPLE IN BRISTOL BAY
CAN PARTICIPATE IN THE HEARINGS? THANK YOU.
SINCERELY,

CAMILLE MARTINZ

TO: SENATOR PARR

FROM: NARELLA JAVIER
7800 DELAIR #162
ANCHORAGE 99504

(H) 333-5738

I SUPPORT SB 747 AND WOULD APPRECIATE YOUR ARRANGING A TELECONFERENCE
ON THIS BILL.

TO: SENATOR PARR

FROM: LESLIE BRECKE
7800 DEBARR #431
ANCHORAGE 99504

338-3252

I SUPPORT SB 747 AND WOULD LIKE TO REQUEST A TELECONFERENCE ON IT.
THANK YOU FOR YOUR ATTENTION TO THIS MATTER.

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE - UPDATE

I. REQUEST

Bill/Resolution No. SB 747
Title An Act relating to midwifery.
Requested by Senator Fischer Date 2-11-82

II. FISCAL DETAIL

Agency Affected Department of Commerce & Economic Development
Program Category Affected Public Protection
BRU, Program, Or Subprogram(s) Affected Regulation & licensing of professions.
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

| | FY 82 | FY 83 | FY 84 | FY 85 | FY 86 | FY 87 |
|--------------------------|-------|-------|-------|-------|-------|-------|
| 100 PERSONAL SERVICES | | 27.9 | 27.9 | 27.9 | 27.9 | 27.9 |
| 200 TRAVEL | | 9.4 | 10.3 | 11.4 | 12.5 | 13.7 |
| 300 CONTRACTUAL | | 16.0 | 17.4 | 18.9 | 20.6 | 22.4 |
| 400 COMMODITIES | | 5 | 5 | 5 | 5 | 5 |
| 500 EQUIPMENT | | 2.8 | | | | |
| 600 LAND & STRUCTURES | | | | | | |
| 700 GRANTS, CLAIMS, ETC. | | | | | | |
| TOTAL | | 56.6 | 56.1 | 58.7 | 61.5 | 64.5 |

FUNDING (Thousands of Dollars)

| | FY 82 | FY 83 | FY 84 | FY 85 | FY 86 | FY 87 |
|------------------------|-------|-------|-------|-------|-------|-------|
| GENERAL FUND | | 56.6 | 56.1 | 58.7 | 61.5 | 64.5 |
| FEDERAL FUNDS | | | | | | |
| OTHER (Specify Source) | | | | | | |

POSITIONS

| | FY 82 | FY 83 | FY 84 | FY 85 | FY 86 | FY 87 |
|-----------|-------|-------|-------|-------|-------|-------|
| FULL TIME | | 1 | 1 | 1 | 1 | 1 |
| PART TIME | | | | | | |
| TEMPORARY | | | | | | |

III. ANALYSIS (See Fiscal Note Preparation Instruction, Section III)

PERSONAL SERVICES - FY '82 salary schedule and benefits.

1 Licensing Examiner I, range 12, gen.govt., 12 mos. 27.9

TRAVEL - 10% inflation factor projected.

Board of Midwifery, 5 members (anticipate 1-Anch, 1-Fbks, 1-Southeast, 1-Kenai area, and 1-Nome area); 3 meetings per year (1 ea. in Anch, Fbks, & S.E), travel costs plus 3 days per diem @\$80/day \$6,000.00

Department staff: 1-licensing examiner to attend meetings of the Board of Midwifery, travel costs plus per diem 1,200.00

1-regulations specialist to hold hearings and assist board in promulgation of regulations, travel and per diem 1,200.00

1-investigator, travel and per diem costs to investigate complaints concerning lay midwifery; average 1 trip every 4 months @\$200/trip plus per diem @ \$80/day 1,000.00

IV. DATE March 25, 1982

PREPARED BY Mariorie Odland

AGENCY Division of Occupational Licensing

Original: Legislative Finance

PHONE 465-2535

cc: Budget and Management

Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/81)

CONTRACTUAL - 9% inflation factor projected.

| | |
|--|-------------|
| Printing of new statute booklets, applications and licenses for midwives desiring to become licensed. | \$ 2,000.00 |
| Meeting notices, regulation publications, mailing costs of application packets and statute booklets | 800.00 |
| General operating costs including phones, computer time (prorated by board), and similar daily costs. | 1,000.00 |
| Development of examination, professional services contract basis, including updates, pool of questions for use by state board, storage in in-house computer system | 5,000.00 |

Licensing/Disciplinary Hearings - Anticipate three hearings per year. In estimating one day hearings, the following costs are considered:

Average 6 hour days:

| | |
|--|-------------------|
| Hearing Officer, @\$75/hr | 450.00 |
| Court Reporter, @\$25/hr | 150.00 |
| 10 exhibits, \$.45 ea. | 4.50 |
| 3 witnesses, 1/2 day ea. @ \$12.50 | 37.50 |
| 1 expert witness, 2 hrs. @ \$150./hr. | 300.00 |
| Transcript, avg. 210 pages @ \$4.50/page | 945.00 |
| | <hr/> 1,887.00 |
| | X 3 |
| | <hr/> \$ 5,661.00 |

Room Rental for examinations:

| | |
|--------------------------------|--------|
| 2 exams per year., 1 day each. | 200.00 |
|--------------------------------|--------|

Proctors for examinations:

| | |
|-------------------------|--------|
| Head Proctor - \$50/day | 100.00 |
| Monitor - \$35/day | 70.00 |

Rental Space - 1 licensing examiner position: 60 sq.ft X \$1.70 X 12 mos. = 1.2

COMMODITIES

General supplies needed by licensing examiner such as tapes for meetings, file folders, paper etc.

.5

EQUIPMENT - one time cost in FY'83.

| | |
|--|------------------|
| 1 desk, double pedestal 60" x 30" | 426.92 |
| 1 chair, posture without arms (contour) | 170.57 |
| 1 typewriter, correcting selectric, dual pitch | 1,028.81 |
| 1 typewriter table | 101.92 |
| 1 credenza, 90" x 62" | 470.90 |
| 1 side chair | 95.15 |
| 2 file cabinets, 4 drawer legal | 505.20 |
| | <hr/> \$2,799.48 |

A GUIDE TO DOCUMENTING A LOCAL PROGRAM

THE CHILD WELFARE RESOURCE INFORMATION EXCHANGE

A Project of

The Children's Bureau
Administration For Children, Youth and Families
Office of Human Development Services
U.S. Department of Health, Education, and Welfare



Prepared by

Mott-McDonald Associates, Inc.
2011 Eye Street, N.W.
Washington, DC 20006

Contract #DHEW-105-76-1130
December 1979



Department of Health and Human Services
Office of Human Development Services
Administration for Children, Youth and Families
WASHINGTON, D.C. 20201

June 24, 1980

Dear Colleague:

From October, 1976 through December, 1979, the Children's Bureau supported an innovative demonstration of technology transfer called the Child Welfare Resource Information Exchange. The goal of the Exchange was to promote the transfer of program and technological developments and knowledge related to services for children at risk with a primary focus on child welfare services. The Exchange provided technical assistance in the replication and implementation of programs, methodologies and materials to improve practice. The child welfare community was kept informed by a bi-monthly bulletin and through the dissemination of program abstracts which provided details on the features of an exemplary program. These two forms of knowledge dissemination and utilization have been well received by child welfare planners, administrators, practitioners, and academicians.

To provide continuity after the Child Welfare Resource Information Exchange completes its close-out activities the Children's Bureau has entered into a cooperative arrangement with Project Share to assume some of its knowledge dissemination and utilization functions.

Project Share is an information clearinghouse sponsored by the Department of Health and Human Services to provide significant information to help improve the management of human services. Project Share acquires, announces, and makes available documents; analyzes and synthesizes these documents; provides computerized literature searches of its data base; and produces and disseminates many monographs and bibliographies on topics of current interest to its users. A quarterly Journal of Human Services Abstracts will be disseminated to interested users. This publication will serve a function similar to the abstract updates formerly sent out by the Exchange.

As indicated in the last issue of the Bulletin there are forty National and Regional resource centers that also can assist you. In the near future we expect to develop additional resources relating to Indian Child Welfare and home-based services. We are pleased to have worked with you in achieving information dissemination leading to program improvement and advancement.

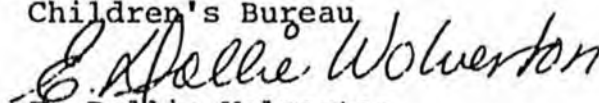
Enclosed for your information are two publications of the Exchange which have not been previously disseminated: A Guide To Documenting A Local Program; revised; Suicide Among Children and Youth: A Guide For The People Around Them.

We also take this opportunity to express our appreciation and commendation to Paul Mott and the staff of the Exchange who successfully demonstrated different approaches to social change.

Sincerely,



Charles P. Gershenson
Director, Program Development and
Innovation Division
Children's Bureau



E. Dollie Wolverton
Project Officer
Program Planning and Innovation
Specialist

Enclosures

A GUIDE TO DOCUMENTING
A LOCAL PROGRAM

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| INTRODUCTION | 1 |
| SECTION I. THE DOCUMENTATION PROCESS | 2 |
| SECTION II. THE DOCUMENTATION REPORT FORMAT | 6 |
| APPENDIX. DOCUMENTATION OF THE TRESSLER-LUTHERAN SERVICES ASSOCIATES ADOPTION PROGRAM | A-1 (following p. 13) |

INTRODUCTION

The purposes of the Child Welfare Resource Information Exchange (Exchange) are to identify successful child welfare programs and practices, and to stimulate, or assist in, the transfer of successful programs/practices to other settings. The resource collection includes operating manuals, handbooks, program descriptions, research studies, state-of-the-art surveys, planning and management tools, and training materials such as curricula, teaching manuals, and student workbooks.

In order to be included in the Exchange, programs/practices must be of benefit to the child welfare field, reflect sound principles of services delivery, have proven results, and possess a high potential for replication. To determine whether potential resources meet these criteria they are evaluated by both Exchange staff and outside reviewers for conceptual soundness, positive evaluative results, and replicability.

The transfers of programs/practices are accomplished through the publication of a bimonthly bulletin and monthly abstracts which permit interested parties to receive more in-depth information directly from the resource developers. On-site consultation services are provided to assist in the adaptation or replication of selected programs.

The assessment of a potential resource for inclusion in the Exchange and the facilitation of the transfer of selected resources require comprehensive documentation of the program/practice. The Exchange staff has found that there are many high quality programs which have not been documented adequately to share with the child welfare field. In addition to making it easier to have a successful program/practice included in the Exchange, adequate program documentation may be beneficial to an agency in other ways, i.e., in efforts to secure program funding, or as a tool in the program planning or evaluation process. The purpose of this guide is to assist child welfare program managers in the documentation of their program efforts by providing both a recommended process and format.

Section I of this guide provides a general discussion of the documentation process, with suggestions for "how to" document a program. Section II presents the recommended format to be used in the preparation of the documentation report. The Appendix provides a sample of the completed documentation of an adoption program, prepared by a member of the Exchange staff.

One final note of introduction. The documentation effort can provide a useful assessment of where your program is, where it's been, and where you would like it to go. Our suggestion is to use the documentation process for redefining and solidifying your program goals, for evaluating its strengths and weaknesses, and for initiating constructive communication among program staff.

SECTION I. THE DOCUMENTATION PROCESS

Program documentation may consume a considerable amount of time, depending upon the size and complexity of the program, and the documentor's familiarity with the program itself. However, the documentation process itself is not complicated.

A. Documentation: Who, How Much Time, Benefit, and Assistance

Answers to several key questions may be useful in considering the costs of undertaking the documentation effort:

- Who is the best person to carry out the documentation effort?
Our experience indicates that a person knowledgeable with the full range of program functions, services, and operations is the best person to conduct the documentation effort. That person may be a current or past employee, or may be an outsider familiar with the program.
- How much time will it take to conduct this documentation effort?
We have found that the time required to complete the documentation effort in the format suggested varies considerably from the more complex to the less comprehensive program. For example, the sample found in Appendix A required approximately 120 hours for an Exchange staff member to complete. The cooperation of program staff and the degree to which supportive documents are readily available will have a major impact on time spent in the effort.
- How can this documentation effort help the program?
Those groups that have completed the documentation effort suggest that it is well worth the time invested. Many point to the increased understanding of the program mission and long-range goals that the involvement in the process can bring; others suggest the completed document has been helpful in gaining increased public understanding and financial support.

B. The Documentation Process: The Major Activities

The process consists of three major activities:

- Information collection;
- Analysis and synthesis of information; and
- Writing the report.

1. Information Collection

The principal sources of information for the documentation effort should be the program's written materials and conversations with program staff. Additionally, the documentor's personal observations of the program's operations can be a valuable source of information.

Written materials may include data sheets, annual reports, funding applications, advertising brochures, operating manuals, case records, and budget documents. The written information should be initially reviewed with an eye toward obtaining a fundamental understanding of the program's operations.

The understanding of the program operations, obtained from the review of the written materials, should be tested and expanded through interviews with key program staff. The documentor should be prepared to engage in informal discussions with these program staff, and be prepared to ask knowledgeable questions concerning the gaps found in the written information.

Personal observations of all phases of the program's operations will provide additional information, and/or raise questions which may not have been previously answered by either the written materials or the initial interviews with program staff. A useful method for observing program operations is to "walk through" all steps of the services program, from intake to case closing or aftercare, from program planning to program evaluation.

2. Analysis and Synthesis of Information

As information is collected, it should be organized into the various sections specified in Section II below. The major categories will be: program environment, program management, program operations (services), and program evaluation.

The analysis of information should seek to assure that there is consistency and continuity among all aspects of the program presented. For example, the documentor will want to assure that all components of the program are reflected in the budget, and that there is a means of providing sufficient data from which a services plan could be developed by the reader of the report.

The synthesis of information, in addition to condensing the material and making it easily understood, may include the development of flow charts, organizational diagrams and other useful graphics, which can be further explained by narrative descriptions.

3. Writing the Report

The documentation report may be written following the format outlined in this guide. (Unlike the sample appended to this manual, you may prefer to single space your final document to cut down on reproduction costs.) The style may be formal or informal, but in any case, the report should be concise (as long as it needs to be, but no longer) and easily understood. Professional jargon should be minimized.

At all stages of its development, the report should be reviewed by key program staff for both accuracy and readability. The finished report should have the approval of the program director before it is sent outside the agency.

C. General Considerations

1. Examples taken from the real-life experiences of your program and its users will be helpful in supporting and making your documentation live. Examples may be a case study of a successful user, interagency cooperative activities, creative ventures, etc.
2. There are many cases in which a picture is worth a thousand words. For example, pictures or diagrams have been found useful in depicting a program's setting and physical plant, its structure, the stages of a user's interaction with an agency, the steps in the planning and management processes, etc.
3. Statistics are an important means by which one can substantiate a program's successes. Statistical charts may be useful in presenting population characteristics of the community served, length of time in the program, follow-up success rate, etc.
4. Evaluation of your program efforts in meeting its objectives is an important consideration in "selling" the success of your program's work to the reader. Both subjective and objective measures may be indicated as clarification of these successes. Evaluative feedback from many sources--users, the community, staff, in addition to the more formal means--might be useful.
5. Wherever possible, a clear "how to" approach is helpful in indicating program accomplishments. To those reading your document, process is every bit as important as output or outcomes. Likewise, approaches that were tried and subsequently rejected may be as useful as those which were successful. Remember that the aim is to provide specific information--including all the learning experiences gained--to others interested in pursuing similar program activities.

SECTION II. THE DOCUMENTATION REPORT FORMAT

This section provides a format for the organization of the documentation report. The suggested content for each element of the report is described. This format is recommended for use in the documentation of all types of child welfare programs. However, the documentor should feel free to add or delete information as required to best describe the specifics of the program to be documented. The documentor should also interpret the subheadings of the program components in a manner which is most suitable for the specific program being documented. This may mean certain sub-elements may best be combined or eliminated to more accurately describe the program.

The recommended format is as follows:

A. Title Page; Table of Contents; Table of Exhibits

B. Introduction

The introduction should present a preview of the documentation report through a general description of its content.

C. Program Summary

The program summary should be a concise (one-to two-page) description of the program, serving as a preview to the entire contents of the document. It should include a review of the program's history and identification of the sponsoring agency, organization, or individual. Also included should be a short description of the population served, the services provided, and the sources of funding.

D. Program Components

For the purposes of the documentation effort, program descriptions may be broken down into the following three components: Program Environment, Program Management, and Program Operations (Services).

1. Program environment

The program environment component should provide a description of the physical, social, and philosophic environment within which the program functions. The following information should be included in this subsection.

a. A description of the political, social or economic circumstances which affect program development and ongoing operations.

In many instances, a program has been developed in response to a penetrating problem recognized by current political, social or economic circumstances. For example, the need for a new program may have been caused by the cutback in funding available for a previously provided service. Or, an increased emphasis on the provision of child protective services may have been occasioned by the reporting of the tragic death of an abused child.

b. A description of the characteristics of the program's setting.

Such a description is important because a program designed to serve a rural poor population may have an entirely different set of needs than does a program in a metropolitan, middle-income community. Therefore, adaptation would be required for the transfer of a program from one setting to another; or replication may be totally prohibited due to the program setting.

c. A description of the population served.

The reasoning for the inclusion of this information is essentially the same as that for the general demographic information. The description of the specific problems of the persons served by the program being documented is necessary for the reader to determine whether replication or modification is necessary and/or appropriate.

d. A description of the philosophy guiding the program's operations.

The philosophic base upon which a program is constructed is an important consideration to the success of the effort, and, therefore, critical for the reader. An example of program philosophy is the belief that it is best to serve children in their own homes rather than placing them in foster care, or that older or physically handicapped children should be freed for adoption rather than maintained in institutional settings.

e. A description of the program's goals.

Goal statements should be a restatement of the program's philosophy in more concise and action-oriented terms. An example of a goal statement may be "to develop or improve the ability of parents to care for children in their own homes."

f. A general description of other resources serving the same client group and the documented program's relationship to them.

A program will always have a limited range of services, sometimes very specialized ones. The program's effectiveness may be a direct result of its users' access to a comprehensive array of other services. It is useful to describe the program's relationship to other available private and public resources such as public assistance, child welfare services, health, mental health, etc., and the types of relationships (contractual, source of referral, cooperative agreements, etc.) that have developed.

2. Program Management

The program management component should provide a description of the program's governance mechanism, its organizational structure, funding, and the management tools used to control program operations.

a. Governance

If the program is a private, not-for-profit, or proprietary agency, a description of the structure, its Board, advisory committees, and their roles in the operation of the program should be included. For example, it may be significant to the operation of the program that the Director does not have responsibility for fund raising, if this function is performed by the Board's Development Committee. For a program in the public sector, the relationship of the program to the government funding source could be significant.

b. Organizational structure

Provide an organization chart, depicting all significant aspects of the program. (See page A-9 for an example.) Provide a description of each staff member's role in the functioning of the program and the qualifications required for each position.

c. Funding and budget

Indicate the amounts and sources of funding for all components of the program's operations. Provide a description for all major budget items, such as the following:

- Personnel (includes paid staff and volunteers);
- Indirect Labor Costs;
- Rent or Building Purchases;
- Furniture and Equipment; and
- Travel.

d. Management Tools

Describe the means used to maintain fiscal and program accountability. For example, an agency may have an automated management information system, utilize management by objectives, or use program planning and budget (PPB) techniques. Append all forms which are used in these processes.

3. Program operations (services)

In most instances the program operations or services component will be the heart of the documentation. This section should provide a description of both the process for the delivery of services to users and the services themselves.

The service delivery process should be described with a case flow chart (See Figure 1 for an example) and an accompanying narrative description of each step in the process. For most programs, this will include most of the elements in Figure 1; however, considerably more detail is possible, and the arrangement of elements will vary from program to program.

a. Intake

The means used by which persons come to the attention of the program and how their needs for services are determined. Sub-elements of intake are:

(1) Outreach

The means used by the program to make its services known and the provision of easy access to them. Examples of outreach techniques are the use of the media for advertising and the maintenance of active media for advertising and the maintenance of active liaison relationships with the schools, courts, hospitals, and other social welfare service providers.

(2) Case screening

The process used to determine whether a person is eligible for the services provided by the program. A description of the screening process should include a restatement of the eligibility criteria. Forms used should be appended.

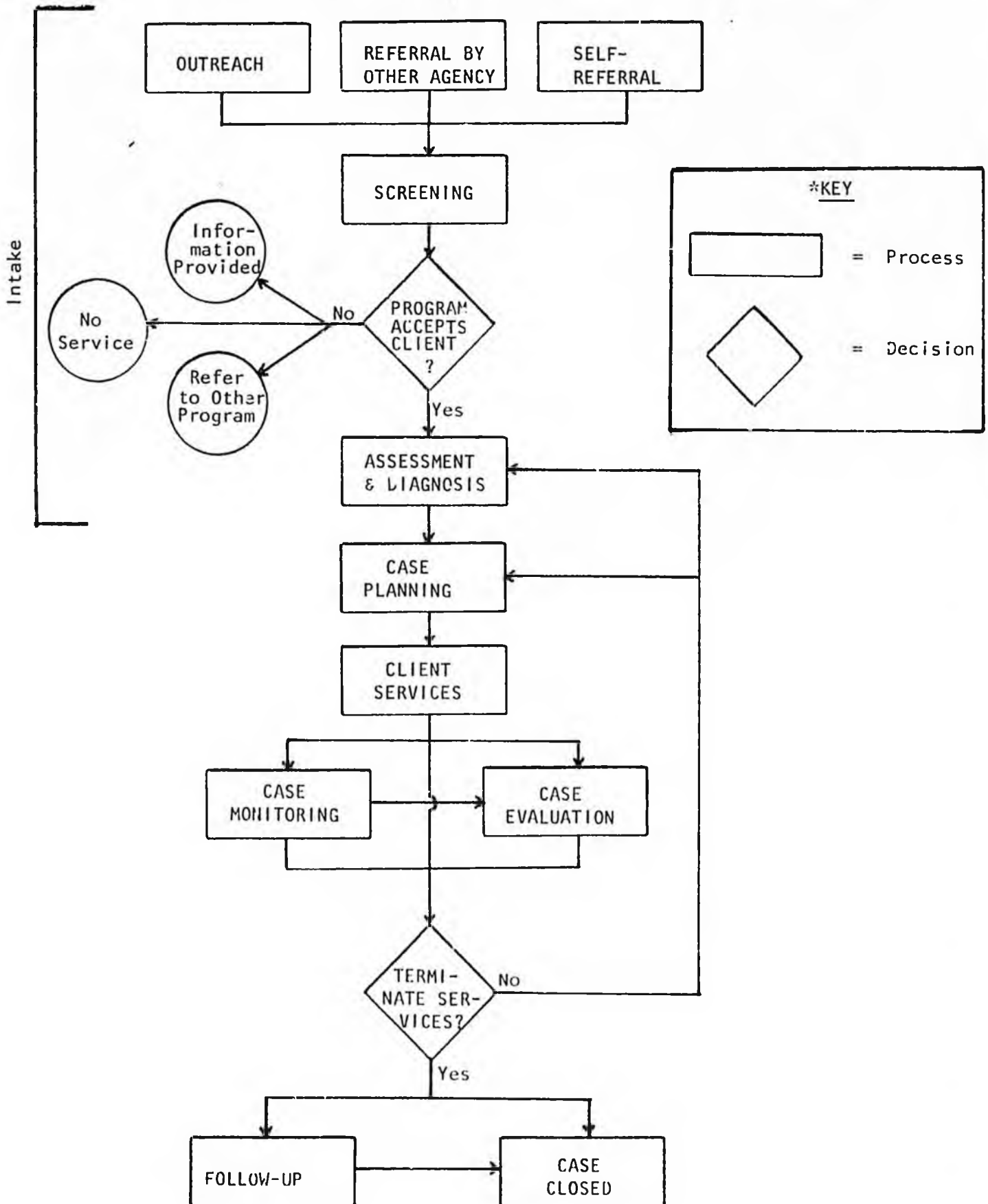
(3) Information and referral (I&R)

The means, in addition to the outreach efforts, by which the program provides information to the public and other service providers about its services, and the means by which referrals to appropriate resources are made for receipt of services not provided by the program.

(4) Case assessment & diagnosis

The process used by the program to obtain a determination of user needs. Emphasis should be given to the role of staff and outside consultants in the assessment and diagnostic processes. Written materials used should be appended.

FIGURE 1: SAMPLE CASE FLOW



b. Case planning

Activities designed to match user needs with a purposeful plan for the receipt of services designed to meet the identified needs should be described. The description should include the means used to set case objectives, service contracts between the user and the program (if used), and a discussion of the role the user plays in case planning. Forms used should be appended.

c. User services

Those activities designed to prevent, solve, or ameliorate user needs through the conduct of the user service plan and the meeting of the case objectives should be presented. Services should be described in terms of the staff who provide the service, the nature of the service and the staff time invested in the provision of the service. Where there are multiple services provided, each one should be described individually, along with the means used for coordinating them to achieve the case objectives. Step-by-step procedures should be described insofar as possible.

d. Case monitoring

This is the on-going process for determining that services are being provided in accordance with the case plan. The description should state how the provisions of services are monitored. Tracking mechanisms, manual or computerized, should be described where used. Forms used should be appended.

e. Case evaluation

The process of determining whether the objectives of the case plan have been met should be described in terms of the means of evaluation (staffing, periodic records review, etc.) used and the data generated on the program's generic effectiveness. Forms used should be appended.

f. Termination of services

The description of the process used to close a case should include both the criteria used for case closings and the means used to terminate services. Data on closed cases (successes vs. non-successes) should be provided.

g. Follow-up services

Follow-up services are the periodic check-up to determine if the services provided have had the desired effect (i.e. how is the person doing?). The description should state the means, frequency, and length of time the program tracks the case once it has been closed.

Throughout the write-up of the operations/services component the documentor should take care to record which staff are responsible for conducting the various functions. Copies of all pertinent forms and written procedures utilized in the operations/services process should be described in the narrative of this section and provided in an Appendix.

E. Program Evaluation

The documentation process itself is not expected to be an evaluation; however, it should report the results of any efforts offering an indication of the program's level of success. This section should include any or all of the following:

1. Formal evaluation

If any formal evaluation of the program has been conducted, the name of the evaluator, the date of the study, and the significant results should be indicated. Charts, statistics, and a narrative summary from the evaluation would be helpful.

2. Case disposition data

Even if no formal evaluation has been carried out, most agencies can compile data indicating client progress over the program's history. How many clients were served? Of those provided services, how many are currently receiving them and how many have been terminated? Of those terminated, how many were successfully placed, diverted or mainstreamed? What were the problems preventing success? How many showed significant improvement, slight improvement, no improvement, or regression? Etc.

3. Success in meeting program goals

Your program should be able to make a statement on the degree to which it has succeeded in meeting the stated goals of the program. This can be accomplished if the program goals are further delineated into measurable objective statements.

4. Testimony

Quotations from current and past clients, community members, referral agencies, etc. can be offered to assist in substantiating a program's claim to success. Results from evaluative questionnaires can be tabulated, and incisive comments quoted. Testimonial letters can be included in an appendix.

5. Replication

If the program's techniques or services have been replicated or adapted by other agencies, or if interest in the program has been indicated through journals, national reports on exemplary programs, etc., this should be indicated.

6. Directions for the future

Finally, the evaluation section may provide the director's, staff's, or documentor's assessment of future activities. In addition, if the program is part of a larger service network, recommendations can be made about how the entire network might be improved. Are there local, state, or federal policies which might be altered to provide strengthened support to service for clients? Do services need to be coordinated on a larger geographic scale or strengthened within the current network? Etc.

APPENDIX

Sample Documentation Report

THE TRESSLER-LUTHERAN SERVICES ASSOCIATES
ADOPTION PROGRAM

Tressler-Lutheran Services Associates
York, Pennsylvania

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SECTION I. INTRODUCTION

This report describes the Adoption Program of the Tressler-Lutheran Services Associates (T-LSA). It is organized into the following three sections.

Section I - Program Summary provides an overall description of the program's organizational structure and purposes.

Section II - Program Components provides a detailed description of all phases of the operation of the Adoption Program. The first subsection describes the physical and philosophic environment in which the program operates. The second subsection provides a full description of all phases of the program's management. The third subsection describes each component of the program's services and their delivery.

Section III - Program Evaluation presents information on the results achieved by the program and its effectiveness.

SECTION II. PROGRAM SUMMARY

Tressler-Lutheran Service Associates (T-LSA) is the multi-service, non-profit operational arm of two separate Lutheran Church-related social services agencies. T-LSA was formed in 1972 as the result of an agreement between Tressler-Lutheran Home for Children (TLHC) and Lutheran Social Services - Central Pennsylvania Region (LSS-CPR). Under terms of the agreement, T-LSA was incorporated to provide all of those services formerly provided by these two agencies, and currently operates under the joint control of TLHC and LSS-CPR.

T-LSA provides a variety of services including individual and family counseling; personal growth and enrichment services; specialized foster care services for adjudicated youth; refugee resettlement, nursery and day-care services; the operation and management of nursing homes and retirement centers; and the adoptive placement of children with special needs. Prior to the 1971 merger of the agencies both also provided traditional adoption services. However, in 1972 the adoption program was redefined, and the focus shifted to the present emphasis on the adoptive placement of children with special needs.

The T-LSA Adoption Program currently is a home-finding program specializing in adoptive placements for children with specialized needs. The program is the "placement arm" for other agencies and generally has no children directly within its custody. Adoption program staff also perform an advocacy function by demonstrating to other agencies that there are families willing and able to adopt children with special needs. Additionally, to help ensure a low rate of disrupted adoptive placements, a broad range of preparation and supportive services are provided to prospective and finalized adoptive families. The program's services are intended to form a continuum from inquiry to follow-up after obtaining the final adoption decree.

SECTION III. PROGRAM COMPONENTS

This section provides a description of the components of the T-LSA Adoption Program. The components are categorized under the following headings: Program Environment, Program Management, and Program Operations (Services).

A. Program Environment

1. Circumstances which affected program development and functioning. The special needs focus of the adoption program was developed because of:

- The recognition of the problems of "waiting children," i.e. those children legally free to be adopted, or those who could be freed for adoption but who remain in foster care placements; and
- The decline in the number of healthy, white infants available for adoption.

2. Characteristics of the services area. The T-LSA Adoption Program operates in twenty-six counties of Pennsylvania, and the states of Maryland and Delaware, as well as the District of Columbia. The Pennsylvania counties serviced are predominately rural, with the largest city within the area being Harrisburg, the State Capital. The other large urban centers within the service area are Baltimore, Maryland; Wilmington, Delaware; and Washington, D.C.

The T-LSA Adoption Program is headquartered in York, Pennsylvania, with branch offices in Williamsport and Altoona.

3. Population served. The T-LSA Adoption Program provides home-finding and adoptive placements for children with special needs. Special needs children are defined as those children legally free to be adopted who are:

- Over the age of eight;
- Family or sibling groups of two or more children;
- Black children, and children of mixed racial parentage;
- Children with medical, emotional or mental disabilities; and
- Children from developing countries.

4. Program philosophy. The Adoption Program utilizes a client-centered approach. The basic assumption is that potential adoptive parents can make the best decisions regarding their interests, strengths, and limitations. Adoptive parents are encouraged to evaluate their own capacities, research other available resources, and then select the children they feel will fit best into their homes. The agency holds no preconceived concept of what makes a family acceptable. It focuses on the needs of the children and the capabilities of each family to provide the emotional resources necessary to care for special needs children.

Adoptable children who have physical disabilities or are of mixed racial heritage are not considered to be "hard-to-place," but rather are considered to have "special needs" which may require greater efforts to find adoptive families with the love, concern and capacity to accept and work with their special circumstances.

Both parents and children can best be served by positive, supportive services. The role of the social worker in the Adoption Program is to help educate the family in the skills that can be used to meet the needs of the children it adopts, and to provide post-adoptive services to support the placement.

This client-centered approach focuses on self determination, an educational process of building on already existing parental skills, self-assessment of strengths and weaknesses, and the ability of the clients to be the primary active decision-makers in the building of their families through adoption. It is the belief of the agency that the program's various service components which support this philosophy reduce the disruption rate even with children who have special needs by making adoption realistic for the adoptive parents.

The Program operates with the belief that it is the responsibility of the community to provide families for its children and, therefore, it works toward reeducating the community with reference to its perception of special needs children.

5. Program goals. The goals of the adoption program are as follows:

- To find permanent, loving homes for institutionalized and foster children with special needs;
- To provide a method for helping adoptive parents to evaluate their capacities and to provide them with additional parenting skills;

- To provide supportive post-adoptive services to families;
- To enable people to become the best parents they are capable of becoming; and
- To broaden public awareness of the needs of waiting children and to advocate on their behalf.

6. Other resources serving the same population, and the program's relationship to those resources. The staff of the Adoption Program maintain regular contact with approximately 100 agencies for the purpose of cooperative home-finding and placement, the sharing of knowledge and experience, and for observing the trends and services in the placement of children with special needs. Concentrated contacts are maintained with approximately 40 agencies throughout the U.S. and Canada, as well as with several international adoption agencies. T-LSA staff work with these agencies, as well as with courts and regulatory bodies.

T-LSA uses existing adoption exchange services to facilitate the placement of available children. Some of these exchanges are as follows:

- ARENA (Adoption Resource Exchange of North America - Child Welfare League of America);
- PACE (Pennsylvania Adoption Cooperative Effort);
- Delaware Valley Adoption Council;
- The CAP book;
- New York State Adoption Exchange; and
- Adoption Exchanges in Texas, Arizona, Virginia, and Indiana.

Additionally, adoption exchange books are used to provide prospective adoptive parents with information on available children.

Upon request, the T-LSA Adoption Program staff provide consultation services to any of the agencies with which the program maintains control. The Director has conducted training workshops for adoption personnel and has made numerous presentations on the Adoption Program to agencies throughout the country.

B. Program Management

1. Governance. T-LSA is the operational arm of two church-affiliated social services agencies: Tressler-Lutheran Home for Children (TLHC), and Lutheran Social Services - Central Pennsylvania Region (LSS-CPR). Both of these agencies are incorporated, nonprofit agencies. Each of them maintains its own assets and elects its own Board of Directors.

The TLHC Board of Directors is elected by the Executive Boards of the Central Pennsylvania and Maryland Synods of the Lutheran Church in America. There are seventeen members of the board. Eleven members are elected by the Central Pennsylvania Synod; four members are elected by the Maryland Synod; the President of each Synod, or a Presidential designee, serves as an ex officio member of the TLHC Board.

The LSS-CPR Board of Directors consists of 16 persons elected by the Board of the Central Pennsylvania Synod of the Lutheran Church in America. The Synod President or a designee serves as an ex officio member of the LSS-CPR Board.

The Executive Committees of both TLHC and LSS-CPR consist of five members each. These two Executive Committees serve as the formal Board of the Tressler-Lutheran Service Associates (T-LSA), the operational corporation.

To oversee the operations of T-LSA, the Boards of TLHC and LSS-CPR meet jointly three times a year. The T-LSA Board meets six times each year.

The central point of executive responsibility for the operation of all three agencies -- TLHC, LSS-CPR, and T-LSA -- is the President, who simultaneously serves as the chief executive officer of all three groups. The staff of T-LSA is ultimately responsible to the President, under the authority of the T-LSA Board of Directors.

2. Organizational structure. Figure 1 is a chart of the overall organizational structure of T-LSA. The two major divisions of services are Church and Community Services, and Residential Services. Each division is headed by an executive.

Under the Executive for Church and Community Services the two service subunits are Counseling and Education, and Children and Youth Services. The Adoption Program is one of four service units under Children and Youth Services; the others are the Community Treatment Program, the Child Advocacy Program, and the Administration for Interagency Relationships Planning.

FIGURE 1

ORGANIZATIONAL STRUCTURE: TRESSLER-LUTHERAN SERVICES ASSOCIATES

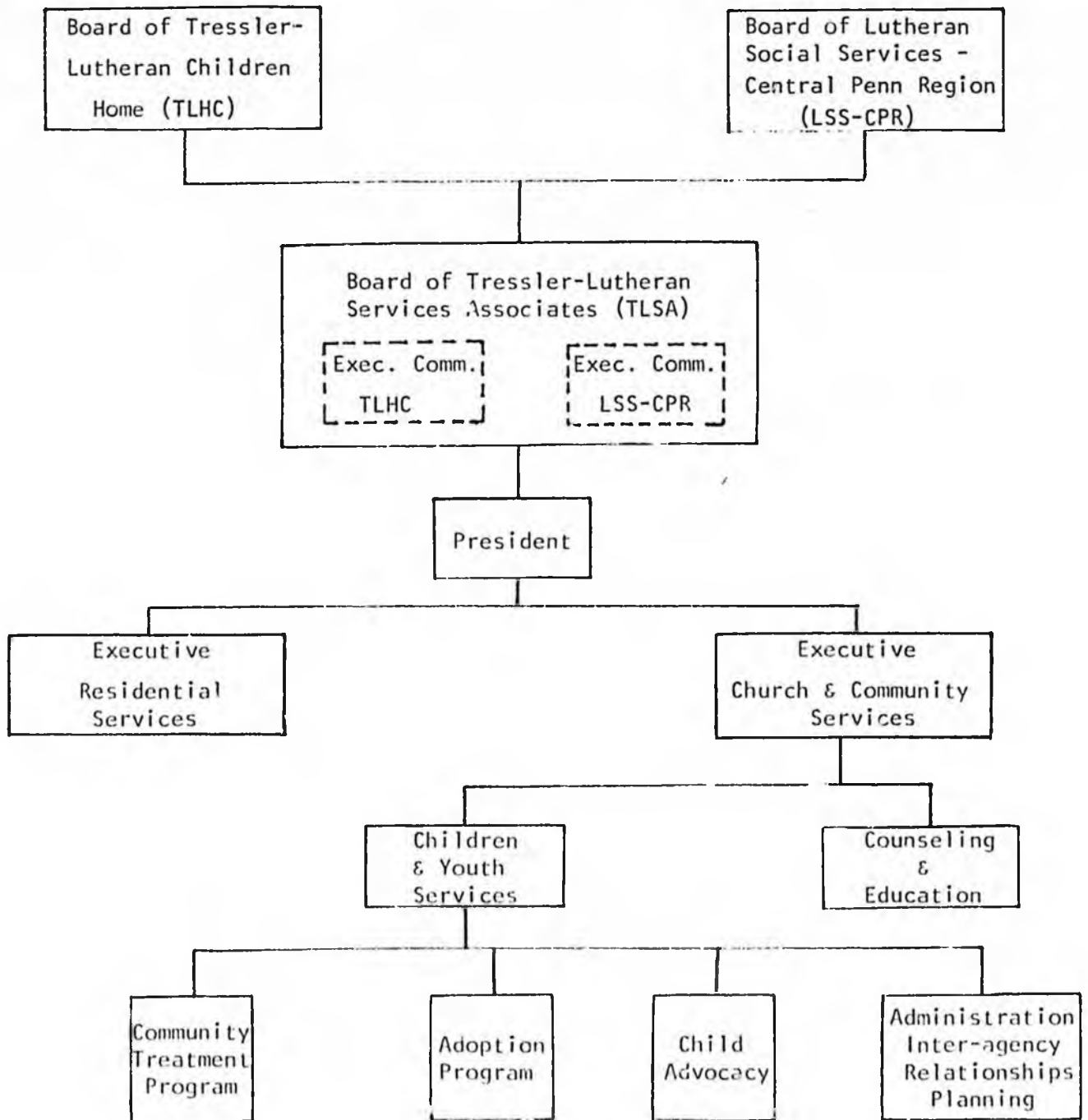


Figure 1-A is a chart of the organizational structure of the Adoption Program.

The staff of the Adoption Program work out of three locations: York, Williamsport, and Altoona, Pennsylvania.

The York office is the main office, and the staff there consists of the Administrator of Children and Youth Services, under whom the Adoption Program operates; the Director of the Adoption Program; an adoption specialist; and a secretary. The Williamsport office consists of two adoption specialists and a clerk/typist. The Altoona office is staffed by an adoption specialist from the Williamsport office on a part-time basis.

The Administrator of Children and Youth Services is responsible for interagency coordination and general services planning. He also supervises three service programs--the Community Treatment Program, which provides foster care, counseling, tutoring and case management to adjudicated youth; the Child Advocacy Program; and the Adoption Program.

The Director of the Adoption Program, in addition to carrying out administrative responsibilities, conducts study groups, provides casework service, attends adoptive parent meetings, provides counseling, makes home visits, edits the newsletters, conducts study training workshops throughout the country, and provides consultation to other agencies upon request. A unique strength of the Program is that the Director is an adoptive parent, and can provide an adoptive parent's perspective to the delivery of professional services.

The adoption specialists conduct study groups, provide casework services to the adoptive families, respond to adoption inquiries, and make presentations on adoption to interested groups and organizations.

The secretary performs clerical tasks, maintains records, provides responses to telephone requests, and types material for the newsletters.

All professional staff members are required to have at least a B.A. and it is preferred that they be working towards attaining a Master's Degree in Social Work, or a related degree. The Director of the Adoption Program is an accredited social worker.

FIGURE 1A

ORGANIZATIONAL STRUCTURE: T-LSA ADOPTION PROGRAM

