The Midwives' Association of Washington State presents

Washington State Orientation Manual

of Licensing and Professional Practice Issues for Midwives

Created September 2011

Midwives' Association of Washington State

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Introduction

Welcome to the practice of licensed midwifery in Washington State. This document was created to help prospective and new midwives understand the laws and access resources that pertain to licensed midwifery in our state.

In addition to an overview of the history of midwifery in WA State and an outline of networking opportunities, you will find links to resources and information for licensing and practicing midwifery in Washington State.

Licensing is required in Washington State in order to practice midwifery, advertise midwifery services, or receive compensation for delivery of such services.

The goal of this document is to provide those applying for direct-entry midwifery licensure with an awareness of the various organizations that provide services for midwives and their practices, as well as an overview of many important aspects needed to obtain your license and open your practice.

Midwifery in Washington State: An Overview

Midwives in Washington (WA) State are licensed as independent practitioners who provide primary maternity care services and attend births in a variety of settings, including homes, freestanding birth centers, and hospitals. Midwifery standards of practice are articulated in the following documents:

- MAWS Standards of Practice: www.washingtonmidwives.org/standards.shtml.
- National Association of Certified Professional Midwives (NACPM) Standards for Practice: www.nacpm.org/nacpm-documents.html.
- MAWS Indications for Discussion, Consultation and Transfer of Care: www.washingtonmidwives.org/indications_for_consultation.shtml.

Washington State recognizes Licensed Midwives (LMs) and Certified Nurse-Midwives (CNMs). Unlicensed midwives in WA can only provide "gratuitous services" as part of the "practice of religion" (as the law "shall not be construed to interfere in any way with the practice of religion, nor be held to apply to or regulate any kind of treatment by prayer." Thus, unlicensed midwifes may not collect "a fee or compensation" for their work or advertise their services. (RCW 18.50.010 and RCW 18.50.030)

The Department of Health (DOH) oversees midwifery applications, the licensing process and the regulation of midwifery in WA State.

- Today there are approximately 100 Licensed Midwives (LMs) in Washington State.
- Most LMs maintain active midwifery practices or are employed in related fields such as public health, family planning, or community clinic administration.
- Since 1980, LMs have attended between 1% and 3% of all births in the state — more than 30,000 births in total. (LMs attended 2.4% of births in WA in 2009.)
- LMs provide comprehensive care to childbearing women from early pregnancy through the postpartum period, attending births primarily in either the woman's home or a freestanding birth center.
- LMs are typically self-employed, carry liability insurance, and are preferred providers in two or more managed-care plans.

Scope of Practice

LMs provide care during the normal childbearing cycle. They consult with physicians when a case deviates from normal, and refer clients if complications arise. In an emergency, a midwife is trained and equipped to carry out lifesaving measures. Their scope of practice includes the following:

- Prenatal care;
- Education and counseling regarding pregnancy, birth and infant care;
- Continuous support during labor;
- Delivery of the baby;
- Care of the newborn;
- Postpartum care; and
- Family planning services.

Midwives may conduct deliveries in hospitals, birth centers or in home settings. They are licensed to perform all of the procedures that may be necessary during the course of normal pregnancy, birth and the postpartum/newborn period, including the administration of selected medications.

Licensure Requirements

- Graduation from a three-year school accredited by the state (or equivalent education/certification).
- Participation in a minimum of 100 births.
- Provision of primary care, under supervision, for a minimum of fifty women in the prenatal, intrapartum and postpartum periods.
- A passing grade on the national certification examination administered by the North American Registry of Midwives and additional state-specific test.

Education and Training

- Bastyr University Department of Midwifery (formerly Seattle Midwifery School): This nationally accredited university offers an articulated Master of Science in Midwifery and is approved by the state. This three-year program provides direct-entry midwifery education that serves as a model nationwide. Most LMs in Washington State are graduates of Seattle Midwifery School. Students must complete one year of prerequisite courses prior to admission. The curriculum is comprised of 130 credits that include

courses in gynecology, embryology, nutrition, midwifery care, pharmacological and alternative treatments, basic health and nursing skills. Students also complete over 1,500 hours of clinical training under the supervision of LMs, CNMs and/or physicians. Naturopathic physicians planning to provide full-scope maternity care can also seek dual licenses by completing this program so as to offer services that blend their two scopes of practice.

- Foreign-trained midwives: These midwives are eligible for licensure in Washington State if they can provide evidence of formal training that is equivalent to that required under state law.

Trends and Statistics

The trending increase in home births noted by the CDC in 2010 can also be seen in WA State. Statewide, there has been a 30.7% increase in births attended by licensed midwives from 2003–2008! Other notable increases seen during that time frame include the following:

- 6% increase in births attended by CNMs;
- 9.9% increase in all midwife-attended births;
- 17.4% increase in birth center births;
- 11.5% increase in home births; and
- 14.1% collective increase in at-home and birth-center births.

The following counties had increases in home and birth-center births during that time: Asotin, Chelan, Clallam, Clark, Ferry, Franklin, Island, King, Klickitat, Lewis, Mason, Okanogan, Pacific, Pend Oreille, Skagit, Snohomish, Spokane, and Whatcom.

Networking

Attending conferences and workshops offered by the Midwives' Association of Washington State (MAWS) is a great way to connect with other local midwives. For information about continuing education opportunities offered by MAWS and other local and national organizations, visit the MAWS website at www.washingtonmidwives.org/external-events.shtml.

In addition, the following individuals have offered to help orient any midwives who are coming to practice here from out of state:

Greater Seattle Area

Elias Kass	www.treehousefamilymedicine.com
Suzanne Thomson	newlifemidwife@msn.com
Melissa Hughes	honeybeetea@gmail.com

Eastside

Charlene Campbell	www.birthjoyeducation.com
Jane Peterson	jane@communitymidwives.com

Tacoma/Olympia/Puyallup

Audrey Levine	www.arcadiamidwifery.com
Marie Wakefield	drmariewakefield@aol.com
Ann Olsen	www.midwifeann.com

Vancouver, WA

Amy Jo Rist	www.vivantemidwifery.com

Central/Eastern

Dzhan Wiley	www.wenatcheemidwife.com
Kristin Eggleston	www.SunriseMidwifery.net
Lorri Carr	www.SunriseMidwifery.net

Olympic Peninsula

Carol Gouchi	www.facebook.com/carol.gautschi
Louisa Wales	mlwaleshall@gmail.com, www.gumnutmidwifery.com

Located in the hub of computer technology, it is no surprise that midwives in WA use social media to stay connected and to network with each other. The Midwives' Association of Washington State maintains an online forum that is secure and protected for its members: www.mawsforum.org.

Elias Kass, ND, LM, CPM, also maintains a more casual Facebook group for conversation, restricted to licensed midwives and midwifery students: www.facebook.com/home.php?sk=group_171733639525722 ("LMs").

Midwifery Licensure

Washington State has a particularly strong history of supporting the development of the direct-entry midwifery profession as well as choice and access to care for childbearing women. The original statute regulating direct-entry midwifery was adopted in 1917 and required two years of schooling. There were no in-state training programs at that time, and most midwives were foreign-trained professionals who had immigrated to Washington from Asia and Europe. The Japanese-American midwives were particularly well-organized, serving large communities in Seattle and Tacoma and maintaining their own professional association.

However, the number of midwives in practice declined into the 1940s as birth moved into the hospital. In addition, the remaining Japanese-American midwives were removed during the Second World War with other Japanese-Americans to internment camps, where they were not allowed to practice midwifery.[1]

The Resurgence of the Midwifery Movement in the '70s

The midwifery licensing law was dormant until rediscovered in the mid-1970s with the onset of the home birth movement. Amid much controversy, the state legislature commissioned a study to determine whether or not the law should be repealed. [2] Based on the study findings, the legislature revisedthestatutin
Based on the study findings, the legislature revised the statute in 1981 to incorporate contemporary international standards for midwifery education and practice. The education requirement was increased from two to three years, specific curriculum requirements were listed, the number of required birth experiences was increased, and a formulary of drugs and devices that midwives could obtain and administer was established.

In 1986, the midwifery licensing law was scheduled for sunset review. This time, both the Senate and the House of Representatives passed the law unanimously! There was one point of disagreement between the two bodies, however:

- State officials argued that the gratuitous services clause in the law should be removed in order to close a loophole that allowed birth attendance by anyone who didn't hold themselves out as a midwife, and didn't charge for their services; whereas
- Representatives of the Midwives' Association of Washington State argued that removing the clause would jeopardize access to care in areas not served by LMs, and should remain until such time as education and licensure were more widely accessible.

This disagreement resulted in a last-minute addition to the law that allowed for a challenge mechanism to the education requirements. A committee appointed by the regulatory agency worked for several years to develop a mechanism that would assure educational equivalency, but the program was never implemented due to lack of funding. Since the mid-1990s, midwives who have not completed Washington State-approved programs have sought licensure through the challenge mechanism. With the establishment of the Certified Professional Midwife credential by the North American Registry of Midwives, the Midwives' Association of Washington State saw an opportunity to create a systematic, consistent process for the review of licensing applications received from midwives who have not completed educational programs approved by Washington State based on the national competency-based standards for national certification. Several attempts have been made over the years to move that idea forward, but financial constraints in the regulatory agency, turnover in the advisory committee, and shifting priorities in the state association have hindered progress.

Midwifery Education

While the old midwifery law was still in place, state officials encouraged a group of lay midwives associated with the Fremont Women's Clinic in Seattle to develop their study group into a school so that they could meet the requirements for licensure. The Seattle Midwifery School was subsequently founded in 1978 and approved by the state that year, with the first graduates licensed in 1979. Graduates and faculty of the Seattle Midwifery School have played significant roles in the

1 Smith, Susan L. Japanese American Midwives: Culture, Community, and Health Politics, 1880-1950. University of Illinois Press 2005.

2 Health Policy Analysis Program. Midwifery outside of the nursing profession: the current debate in Washington. Seattle (WA): University of Washington, School of Public Health and Community Medicine, 1980.

national midwifery movement, serving as officers and board members of MANA, NARM, MEAC, and NACPM.

The next midwifery program was approved by the state in 1984. Located at Bastyr Naturopathic College, the program was designed exclusively for naturopathic students and physicians. This followed an earlier court ruling that the scope of practice of naturopathic physicians in Washington State did not include attending births, and that they would need to be licensed as midwives if they chose to do so.

In 2010, Seattle Midwifery School merged with Bastyr University to become the new Department of Midwifery in Bastyr's College of Natural Health Arts and Sciences, and Bastyr announced its plan to bring the naturopathic midwifery program to a close. The only Washington-based midwifery education program is also the first direct-entry midwifery program to offer a master's degree in a regionally accredited university.

Access to Midwifery Care

The number of LMs and the percentage of midwife-attended births have both grown steadily over the years. There are now approximately 110 licensed midwives in Washington State, and in 2009 they attended 2,130 births (2.5% of all births in the state). Six counties have reported 5% or more of all births as being attended by LMs.[3]

The Washington Department of Social and Health Services made the first official recommendation to increase utilization of midwives in state maternity care in 1988. The following year, the legislature added midwifery students to the state's health professional scholarship program, and midwives were later included in the health professional loan repayment program. (41) Scholarship recipients, who must commit to work in work in health professional shortage areas, have set up new practices and found employment in agencies that serve childbearing families. Midwives who participate in the loan repayment program are employed in qualified midwifery practices or birth centers that provide care in under-served areas.

Medicaid

The Washington State Medicaid program recognized licensed midwives as qualified providers in the early 1980s, but reimbursed only for prenatal and postpartum care given that Medicaid did cover home births or births in unlicensed facilities; after the birth-center licensing law was adopted in 1986, Medicaid added reimbursement for deliveries that occurred in birth centers. After years of consumer and professional pressure to expand coverage, a task force was appointed by the Department of Social and Health Services that ultimately recommended that Medicaid policies be changed to cover home birth services. A pilot project was started in 1999 and the results were so positive that the project was ended and reimbursement fully implemented.

In 1993, responding to public demand for healthcare reform, the legislature adopted a number of laws affecting the delivery of health services. Certain insurance carriers were required to provide for the inclusion of every category of licensed health professional, a mandate that includes LMs (who are considered to constitute a different category than CNMs). [4] The state insurance commissioner committed resources to assure access to the full range of healthcare services by addressing barriers to integrating every category of provider into all health plans in the state. To support insurer compliance with the law, the Insurance Commissioner invited representatives of health plans to join LMs and other healthcare providers in a Clinician Workgroup on the Integration of Complementary Medicine. The workgroup's report was another landmark document that has been useful in establishing better communication and awareness. [5]

Managed-Care Plans

During this same period, managed-care plans were gaining market share rapidly in the state, and Medicaid began contracting with managed-care plans for the provision of services to low-income women. Since managed-care plans typically limit the providers allowed in their networks to those with professional liability insurance, there was a real possibility that LMs who didn't have access to insurance would be excluded from third-party payment. To address this problem, in 1993 legislation was passed to create a Joint

3 Washington State Department of Health, Center for Health Statistics. Birth Data Tables: Natality Table C7. Birth Attendant by County of Occurrence, 2009. http://www.doh.wa.gov/ehsphl/chs/chs-data/birth/download/2009.xls

4 Every Category of Provider: Revised Code of Washington 48.43.045. Olympia (WA):1993.

5 Report of the Clinician Workgroup on the Integration of Complementary Medicine. 2000.

Underwriting Association (JUA) that required all liability carriers in the state to participate in underwriting professional liability insurance for LM, CNMs and licensed birth centers. [6] (39).

Another helpful product of the health reform efforts was the publication of a comprehensive State Health Personnel Resource Plan in 1994. LMs were recognized in the plan as primary care providers for maternity care, and once again there was a recommendation to increase their utilization. [7]

Finally, in 2000, the legislature took one additional step to assure that women could access midwifery care: it added licensed midwives to a Washington State law that requires private health insurers to provide direct access to health-care services for women. Women must also be allowed to choose from a network of healthcare providers, including LMs, without first having to visit a primary care doctor.

In a 1998 survey of all LMs residing in Washington State, 65% of the respondents were in clinical midwifery practice and 23% were doing related work in public health departments, physician's offices, community clinics, or family planning organizations. The midwives reported receiving payment from all sources, including self-pay, fee-for-service insurance plans, preferred provider and managed-care organizations, and Medicaid (both fee-for-service and managed care). Most midwives reported having one or more managed-care plan contracts. The median number of contracts was three per midwife. Managed care plans, including those covering Medicaid-eligible women, accounted for 37% of all payment received. Medicaid, covering clients enrolled in managed-care plans and those in the fee-for-service group, accounted for 34% of all payment received. In a follow-up survey done in 2004, the median number of contracts reported was seven per midwife. Managed-care plans, including those covering Medicaid-eligible women, had grown to 63% of all payment received. Meanwhile, Medicaid, covering both clients enrolled in managed-care plans and those in the fee-for-service group, had expanded to 41% of all payment received. [8]

Group Health Cooperative of Puget Sound was one of the first managed-care plans in Washington State to recognize the potential benefit of providing home birth and direct-entry midwifery services. (45) Group Health has contracted with licensed midwives since 1996 to make home birth services available to all plan members. The Group Health Cooperative's involvement with direct-entry midwives followed a 1995 survey in which they found that 8% of their members were interested in the idea of a midwife-attended home birth, and might use such a service if Group Health would provide the same benefits for a home birth that it provides for an in-hospital birth. An internal task force determined that licensed midwives were best qualified to provide home birth services and developed a framework to support integrating them into the co-op. Group Health enrollees may self-refer to a licensed midwife. The midwife provides all prenatal, labor, birth, and newborn postpartum care, and consults with Group Health physicians and nurse-midwives as needed. When home- or birth-center-to-hospital transports are indicated, they are accepted within the context of the whole system of care. CNMs employed by Group Health may also be involved in the care of women who are transferred to a Group Health Hospital from a home birth. Unfortunately, despite their early decision to include LMs, Group Health has not entered into any new contracts with midwives for many years.

Increasing Access to Midwifery

Midwives have developed a variety of strategies for increasing or improving access to their services. Certainly, the establishment of licensed birth centers has contributed to the growth in out-of-hospital birth across the state. Most owners of birth centers have created mechanisms for granting privileges to midwives who meet their criteria, thereby extending access to the facility to a broader array of practitioners. Many midwives also engage private billing services to assist with health plan contracts, claims processing, etc.

Because the midwifery profession is still relatively small in Washington State, the costs of the licensure program have been a matter of debate for many years. In 2007, the legislature commissioned a cost–benefit analysis from the Department of Health on licensed midwifery. This independent analysis found that licensed midwives directly save the state at least $473,000 per biennium in cost offsets to Medicaid when women give birth at home or in free-standing birth centers. This was a very conservative estimate considering that the figures reflect only avoided costs

6 Midwives and Birthing Centers — Joint Underwriting Association: Revised Code of Washington Chapter 48.87. Olympia (WA):1993.

7 Washington State Department of Health, Health Systems Quality Assurance, Staffing the New Health System: The 1995–1997 Biennial Report of the Health Personnel Resource Plan Statutory Committee, Olympia, WA: Washington State Department of Health, 1994.

8 Myers-Ciecko, Jo Anne. Barriers to out-of-hospital maternity care: Comparing midwives' experiences in 1998 and 2004. Paper presented at the American Public Health Association Annual Meeting, Washington, DC, 2004.

associated with licensed midwives' lower Cesarean-section rates. When facility fees and other medical procedures — such as epidurals and continuous electronic fetal monitoring — are factored into the equation, the actual savings to Medicaid jumps to approximately $3.1 million per biennium. These savings occurred during a period when licensed midwives attended fewer than 2% of the births in the state. [9]

With utilization and outcome data in hand, and now these cost-savings reports, the Chief Medical Officer of the Washington State Medicaid Program has taken a public stance in support of expanding the role of licensed midwives in the provision of care to women on Medicaid. He has acknowledged the significant role that licensed midwives can play in reducing the C-section rate, and pledged his support for an out-of-hospital VBAC pilot project.

Midwife–Physician Relations

LMs in Washington State have a duty to consult with licensed allopathic or osteopathic physicians whenever there are significant deviations from normal in either the mother or the infant; this is a requirement carried forward from the original 1917 licensing law that did not define or specify what conditions might be considered significant deviations from normal. When the law was revised in 1981, the Legislature, recognizing midwives as autonomous, well-educated professionals who could meet international standards for education and practice, determined that it was not necessary to provide any more specific guidelines. Washington's position was unusual during that time period, as most states that regulated midwifery did not require formal education but clearly limited whom midwives could care for and/or specified in detail when midwives must consult or refer care. The dynamic relationship between educational requirements, autonomy, and scope of practice was explored at length in the legislative study completed in 1980, and is still a useful resource to those interested in this subject. [10]

Preserving the autonomy of midwifes and avoiding legally defined limitations on the scope of practice while promoting safety and accountability, has been a priority of the Midwives' Association of Washington State ever since. In the 1990s, as LMs were gaining ground and getting the attention of policy-makers concerned about improving access to care, the state medical association started raising concerns about the quality of care provided by midwives while objecting to the undefined scope of practice. For several years, the medical association argued in the legislature that midwives should be supervised by physicians and their practices limited, while MAWS successfully defended the opposing position. Tired of the inter-professional turf battle, the legislature asked representatives of the professional organizations to resolve their differences outside of the legislative arena. Beginning in 1995, the Midwives' Association of Washington State, Washington State Medical Association, and Washington Obstetrical Society have held a series of meetings to exchange information, identify problem areas, and develop mutually acceptable guidelines for consultation and referral. MAWS conducted a thorough review of the best available evidence and gathered examples of guidelines from other states and countries to present at these meetings, and subsequently drafted a document titled "Practice Guidelines for Risk Screening and Indications for Consultation and Referral." While the document never received endorsement from the physician organizations, the series of meetings did serve to address some of the previous misunderstandings.

Many LMs enjoyed very positive consulting relationships with physicians during this period. Some well-established practices had developed long-term relationships with physicians and could call on them as needed. On the other hand, physicians in some communities remained adamantly opposed to midwifery and out-of-hospital birth, and midwives found it extremely difficult to obtain the necessary consultation services. The situation began to worsen across the state for all midwives as new liability concerns among physicians and hospitals grew in the early 2000s. Not only was consultation more difficult, but transferring care to a hospital during labor was increasingly problematic.

The Midwives' Association of Washington State, determined to frame this as a health system problem, brought the issue to the attention of the Washington State Department of Health Perinatal Advisory Committee. The committee agreed, and in 2004 it appointed a task force to study and improve the process of transferring women and their babies from a planned out-of-hospital birthing location to an acute-care hospital when a higher level of care became necessary. (The task force is a cooperative effort of obstetrician–gynecologist physician leaders and licensed midwifery leaders, as well as those with expertise in public health and policy.) The

9 Health Management Associates. Midwifery Licensure and Discipline Program in Washington State: Economic Costs and Benefits, 2007.

10 Health Policy Analysis Program. Midwifery outside of the nursing profession: the current debate in Washington. Seattle (WA): University of Washington, School of Public Health and Community Medicine, 1980.

licensed midwife members, working with MAWS, developed a document titled "Planned Out-Of-Hospital Birth Transport Guidelines." These guidelines have been reviewed and approved by members of the Statewide Perinatal Advisory Committee, the Midwives' Association of Washington State, and the Physician-Licensed Midwife Work Group. As part of the next phase of this project, midwives and physicians across the state have begun to meet with the goal of forging more intentional relationships to improve communication and client care. Several hospitals have been identified as locations at which to begin piloting this important work.

Professional Liability

In 1993, the legislature created a Joint Underwriting Association (JUA), requiring participation by all liability carriers in the state, to assure that LMs, CNMs and licensed birth centers could purchase malpractice insurance. [11] The board of directors of the JUA is made up of LMs and representatives from the participating insurance companies. They undertake a variety of duties:

- determine assessments;
- discuss current issues facing midwifery;
- discuss pending claims and vote on settlement offers;
- determine the rate-change proposal to file with Office of Insurance Commissioner; and
- discuss results of Professional Liability Reviews.

An administrative service (hired by the JUA) carries out the day-to-day functions, including selling the policies, providing risk-management services, and assisting midwives through the claims process when sued. [12] MAWS laid the initial groundwork for a quality assurance mechanism that was further developed by a midwife-owned private company that now provides risk-management services through contracts with the JUA. The Practice Liability Reviews (PLR) process is a central part of the risk management program mandated by the JUA statute. The review includes a self-report of practice statistics, a site visit with chart review, and evaluation of informed consents and other practice documents. [13] Professional liability insurance has opened doors for midwives who want to make their services available through private insurance plans, and is valued by many because it protects personal assets in the event of a malpractice suit. At the same time, there is the added expense of premiums and certain restrictions that apply in terms of what is covered by the insurance.

Quality Assurance

MAWS first created a quality assurance program in the 1980s in collaboration with the state chapter of the American College of Nurse-Midwives. This program included a practice review component that involved teams of midwives visiting each other's practices, with everyone taking a turn as reviewers. The model fostered mutual understanding and support among both types of midwives and across practice settings. Unfortunately, as malpractice concerns starting heating up in the late 1980s, the organizations were advised to end the reviews out of concern that their observations were "discoverable," i.e., midwives could be called to testify against each other on the basis of the reviews, whereas hospital-based case reviews were protected.

Once again, as part of the health reform legislation passed in the 1990s. the state allowed other facilities and organizations to created protected quality assurance programs, provided they met certain requirements for consistency, fairness, and so on. In 2004, the Quality Improvement Program (QIP) administered by MAWS was approved by the Washington State Office of Quality Assurance. [14] The QIP includes both peer review and incident review mechanisms, and participation is required for membership in the association. MAWS core documents, including the "Guidelines for Consultation and Referral," are primary references, along with other current evidence used in reviewing cases. The QIP, developed and administered by the midwifery profession, has been an important defense in maintaining professional autonomy and accountability against those who would argue that the state or other professionals should have more control over midwifery practice.

11 Midwives and Birthing Centers — Joint Underwriting Association: Revised Code of Washington Chapter 48.87. Olympia (WA):1993.

12 Myers, Suzy and Jo Anne Myers-Ciecko. Midwifery and Malpractice Insurance: The Washington State Joint Underwriting Association for Midwifery and Birthing Centers. Paper presented at the American Public Health Association Annual Meeting. Washington, DC, 2004.

13 www.washingtonjua.com/PLR.htm. Downloaded September 2, 2011.

14 www.washingtonmidwives.org/maws-qmp.shtml. Downloaded September 2, 2011.

Applying for a License to Practice Midwifery in WA State

Applications and forms required for licensure are all available online:

- Application for licensure (DOH > Licensing/ Certification > Midwives): www.doh.wa.gov/hsqa/ Professions/midwifery/documents/midwifeApp.pdf.
- Other forms for licensure: www.doh.wa.gov/hsqa/ professions/midwifery/forms.htm.

Obtaining a Midwifery License in WA State

Students who attend a midwifery school approved by WA State can apply for licensure, and sit for the required state and national midwifery exams, once their transcripts have been provided to the DOH to indicate they have completed the courses required by the state to help ensure entry-level competency through "the provision of adequate clinical and didactic instruction" (RCW 18.50.045).

- Midwifery Schools approved by WA State include the following:
  - Bastyr University Department of Midwifery (formerly Seattle Midwifery School)
- The curriculum requirements for approved schools are outlined in WAC 246-834-140.

As part of the internships/preceptorships/apprenticeships of students attending these approved schools, students must also complete the number of births, prenatal and postpartum visits and gynecological exams required by the state:

- Each student must undertake the care of not less than fifty women in each of the prenatal, intrapartum and early postpartum periods…A candidate for licensure must observe an additional fifty women in the intrapartum period in order to qualify for licensure. (WAC 246-834-140)

Licensure in WA State can also be obtained by completing a challenge process (regulated by the DOH) that was developed to enable midwives who did not attend a WA State-approved school to apply for licensure by demonstrating equivalent training and competency:

- WAC 246-834-065 outlines that these applicants can demonstrate that they have "completed a program preparing candidates to practice as a midwife provided such program is equivalent to the minimum course requirements of approved midwifery programs in Washington at the time of applicant's program completion."
- WAC 18.50.040 details the requirements that must be met by applicants, including:
  a. "Obtaining a minimum period of midwifery training for at least three years including the study of the basic nursing skills that the department shall prescribe by rule. However, if the applicant is a registered nurse or licensed practical nurse under chapter 18.79 RCW, or has had previous nursing education or practical midwifery experience, the required period of training may be reduced … to a period of less than two years ...
  b. Meeting minimum educational requirements which shall include studying obstetrics; neonatal pediatrics; basic sciences; female reproductive anatomy and physiology; behavioral sciences; childbirth education; community care; obstetrical pharmacology; epidemiology; gynecology; family planning; genetics; embryology; neonatology; the medical and legal aspects of midwifery; nutrition during pregnancy and lactation; breast feeding; nursing skills, including but not limited to injections, administering intravenous fluids, catheterization, and aseptic technique; and such other requirements prescribed by rule.
  c. For a student midwife during training, undertaking the care of not less than fifty women in each of the prenatal, intrapartum, and early postpartum periods, but the same women need not be seen through all three periods ...
  d. Observing an additional fifty women in the intrapartum period before the candidate qualifies for a license."
  (www.apps.leg.wa.gov/rcw/default.aspx?cite=18.50.040)

Specific Steps to Obtain a License Through the Challenge Process

- If you are an applicant who has not attended a state-approved midwifery school but has completed an internship/preceptorship/apprenticeship in Washington State and you are planning on practicing here, the following are the steps you must take to obtain a license:
  1. Complete the Washington State Application
  2. Submit all documentation required for the application, including transcripts sent directly from your midwifery school and letters of

recommendation.

- Clinical management requirements are detailed here: www.apps.leg.wa.gov/WAC/defaultaspx?cite=246-834-065.
- In addition to transcripts, "Foreign graduates, and applicants applying for credit toward educational requirements need to supply more information regarding their program and cause their school to provide information so that it can be determined if they are of equal requirements. Foreign applicants must also have proof of their licensure in the foreign jurisdiction sent directly from the agency from which it was issued. Credit toward educational requirements for licensure of unlicensed midwives will be considered on a case by case basis. Existing rules are used to make a determination." (SOURCE: www.doh.wa.gov/hsqa/professions/midwifery/documents/CredReqs.pdf)
- Existing rules that outline the curriculum requirements for approved schools can be found in WAC 246-834-140.

3. Complete the NARM (North American Registry of Midwives) Application process to become a Certified Professional Midwife (CPM). The two most common routes for aspiring midwives to become a CPM are to apply after either attending a MEAC-accredited midwifery school or complete the NARM Portfolio Evaluation Process (PEP).

- For more information about becoming a CPM, visit: www.narm.org/certification/how-to-become-a-cpm/
- For more information about midwifery schools accredited by MEAC (the Midwifery Education Accreditation Council), visit: www.meacschools.org/accredited_schools.php.

4. Take the NARM examination (it is possible to take this exam in Washington State by scheduling it with the DOH). For more information about the NARM exam, visit www.narm.org/testing/testing-information/.

5. Take the state specific examination to be scheduled through the WA DOH.

If you are a midwife with a **CPM** coming to Washington State from another state or country, the following are the steps you must take to obtain a license:

- Complete the Washington State Application:
  - NOTE: "Foreign graduates, and applicants applying for credit toward educational requirements need to supply more information regarding their program and cause their school to provide information so that it can be determined if they are of equal requirements. Foreign applicants must also have proof of their licensure in the foreign jurisdiction sent directly from the agency from which it was issued. Credit toward educational requirements for licensure of unlicensed midwives will be considered on a case by case basis. Existing rules are used to make a determination." (SOURCE: www.doh.wa.gov/hsqa/professions/midwifery/documents/CredReqs.pdf)
- Submit NARM scores directly from NARM, as well as any other documentation (such as transcripts) needed for the application.
- Take the State Examination by scheduling it directly with the Department of Health.

For more detailed information, please see Appendix B.

In Washington State, all midwives and applicants are also required to have training in HIV/AIDS prevention. There are several options for training, including classroom experiences and online sessions. The state maintains an active list of these options online: www.doh.wa.gov/cfh/hiv/prevention/training/default.htm

Practicing Midwifery in Washington State — Duties and Responsibilities:

In WA State, LMs practice as independent practitioners who are required to consult when there is a deviation from normal. As primary maternity care providers, LMs also have a number of other duties and responsibilities:

Birth Certificate Filing
LMs fill out and file birth certificates:
www.doh.wa.gov/ehsphl/chs/chs-data/Public/WaBirthForm2010.pdf

Other Required Documentation
Paternity Acknowledgement forms must be ordered and provided to unmarried clients:
www.dshs.wa.gov/dcs/services/providers.asp#p3

Mandatory Reporting
LMs are required to report known or suspected child abuse or neglect:
www.dshs.wa.gov/ca/safety/abusereport.asp

Notifiable Conditions and Diseases
Midwives, as healthcare providers, are required to report any notifiable conditions and diseases to the Department of Health if a client is found to have one of the conditions or diseases outlined here: www.doh.wa.gov/notify/other/providerposter.pdf (Chapter 246-101 WAC)

Providing Clients with Informed Choices about Screening and Diagnostic Testing
Midwives are required to offer certain screening and diagnostic options to their clients:

- The Board of Health standards for screening and diagnostic tests are outlined in WAC 246-680-020: www.apps.leg.wa.gov/WAC/default.aspx?cite=246-680-020.
- Midwives are required to provide information on prenatal testing and cord blood banking as outlined in RCW 70.54.220: www.apps.leg.wa.gov/RCW/default.aspx?cite=70.54.220.
- The Washington State Code regarding the use of eye prophylaxis can be read as "item e" on www.apps.leg.wa.gov/WAC/default.aspx?cite=246-100-202.

Washington State has an Office of Newborn Screening that tests babies born in Washington State to rule out treatable disorders that exist in newborns who usually appear healthy at birth. Without screening, babies with these disorders are not likely to be detected before disability (such as brain damage) or death occurs. The testing and follow-up services are designed to enable early diagnosis and treatment. Midwives typically run these tests for newborns at postpartum (PP) visits (recommended screening intervals are 24–48 hours PP for the first sample and 7–14 PP for the second sample). Order pamphlets and forms, read the provider manual, and learn more online: http://www.doh.wa.gov/EHSPHL/PHL/Newborn/default.htm.

Relevant Statute (Laws and Codes):
Links to Washington State laws and codes related to midwifery that outline the requirements for licensure: www.washingtonmidwives.org/links.shtml#govt.

Legend Drugs and Devices
Washington State LMs can use items outlined in the following legend drugs and devices:
www.apps.leg.wa.gov/WAC/default.aspx?cite=246-834-250.

Access to Professional Services — Liability Insurance, Lab and Ultrasound Providers

In Washington State, LMs have access to a wide variety of professional services, including liability insurance, and laboratory and ultrasound services. More information about billing services and insurance contracting is provided in the pages ahead.

Professional Liability Insurance

The Washington State Midwifery & Birthing Center Joint Underwriting Association provides professional liability coverage to LMs, CNMs, and licensed birth centers.

Go to www.washingtonjua.com for rates, forms, and other information. There is a specific section with FAQs for new midwives, as well as details on the discount available to midwives who start practice within one year of first obtaining a midwifery license in Washington State.

If you have any questions, please email Liz Chalmers at Liz@WashingtonJUA.com.

Setting up accounts with Laboratory and Ultrasound Service Providers

Access to laboratory testing and ultrasound evaluation are important components of comprehensive midwifery care. Establishing provider accounts is similar for both types of services.

Ultrasound service locations can be an outpatient service at your local hospital, an independent business, or a specialty clinic. After identifying your local service providers, request to speak to a client representative. The representative will assist in establishing an account, and provide ultrasound requisition forms and informational materials for both healthcare providers and their clients. After receiving ultrasound results, the staff radiologist is available to clarify notations on the report or for consultation regarding abnormal findings. It is important to be aware of the different options within your community and region, such as locations for urgent care or Level III ultrasound services. Convenience of location for your clients, timeliness in appointment availability, technical competence, cost and services provided are all important considerations when choosing where to refer a client for ultrasound evaluation.

For laboratory testing, it may be helpful to speak with local midwives or area healthcare providers when selecting your laboratory service provider(s). The client services representative for the laboratory can assist you in establishing your provider account, design custom requisition forms, and provide laboratory collection supplies. Free supplies include items such as a centrifuge, lock box, venipuncture supplies, urinalysis and culture collection supplies, pap collection vials, etc. In addition to collecting your own samples for laboratory samples, the client services representative can provide you with information about how to order tests through Patient Services Centers. These centers can be invaluable in providing timely laboratory evaluation outside of routine prenatal visits.

The services provided may differ slightly between laboratories and based on your geographic location. For example, Quest Laboratories provides a completely online ordering system that enables you to create patient accounts (and therefore not continually input contact and insurance information), order lab tests, print requisition forms and sample labels, review results, and input all laboratory data into an electronic client chart.

Some links to laboratory service providers:

Quest Diagnostics : www.questdiagnostics.com

PACLab Network Laboratories www.paclab.com

Laboratory Corporation of America (joined with Dynacare) www.labcorp.com

Puget Sound Institute of Pathology (PSIP): www.psip.com

Your local hospital may also provide laboratory services.Your region may also have a pathology lab for paps and possibly placental investigation if needed.

Midwifery Organizations

Midwifery organizations and associations exist to assist midwives in their work of supporting mothers, babies, and families, and to transform maternity care.

The Midwives' Association of Washington State (MAWS)
MAWS exists to promote the health and well-being of women and babies through the development and support of the profession of midwifery in keeping with "the Midwives Model of Care" from the International Confederation of Midwives. They offer resources, support, continuing education opportunities, and guidance to the state in regard to the policies and rules related to midwifery. MAWS is the professional association for midwives in the State of Washington. Professional MAWS membership confers many benefits, including access to state-sanctioned and protected peer review and professional liability insurance that enables midwives to become participating in-network providers with health insurance companies (including Medicaid).

Visit MAWS online at www.washingtonmidwives.org. Receive the MAWS E-newsletter for FREE! Sign up today at www.tinyurl.com/mawsnews-signup.

Midwives new to licensure in Washington receive their first year of membership to MAWS free! Contact info@washingtonmidwives.org for more information.

For a list of other local, national and international midwifery organizations, see the end of this manual.

Topics for Midwifery Practice
Please visit the following links, which will connect you to the MAWS website (www.washingtonmidwives.org) to learn more about these topics as they relate to Washington State:

- HIPPA: www.hhs.gov/ocr/privacy/hipaa/understanding/index.html
- Standards for the Practice of Midwifery: www.washingtonmidwives.org/standards.shtml
- Indications for Consultation in an Out-of-Hospital Midwifery Practice: www.washingtonmidwives.org/indications_for_consultation.shtml
- Shared Decision Making: www.washingtonmidwives.org/assets/Shared-Decision-Making-POSITION-STATEMENT4.15.pdf
- Expanding Clinical Procedures: www.washingtonmidwives.org/clinical_procedures.shtml
- Practice Updates: www.washingtonmidwives.org/practice-updates.shtml
- Clinical Guidelines: www.washingtonmidwives.org/guidelines.shtml
- Clinical Forms: www.washingtonmidwives.org/clinical-forms.shtml
- Continuing Education: www.washingtonmidwives.org/external-events.shtml

The "Quality Management Program" of MAWS

The Quality Management Program (QMP) is a state sanctioned and legally protected program, established by MAWS in 2003 and administered by the QMP committee, whereby midwives can, in confidence, freely discuss and be supportively evaluated by a group of their peer midwives, safe from subpoena or legal inquiry. Engaging in activities which strive to encourage continuous quality improvement is a public demonstration of the midwifery profession's commitment to reflective self and peer evaluation with the goal of providing safe responsible family-centered maternity care. Two branches of this program have been described:

a) Peer review, which each midwife must complete on a regular basis every 2 years with at least 3 other professional MAWS members (ie midwives practicing legally in Washington state), and

b) "Incident review", which is organized by the QMP committee and is conducted by a specially convened panel whenever an outcome occurs which meets "sentinel event" criteria.

The Peer Review Process is a routine retrospective educational review of 5 cases, every two years, by at least 3 other professional MAWS members, to provide peer feedback, identify areas of practice needing improvement, and maintain a high standard for the midwifery model of care and the profession. These peer reviews may be initiated by the midwife herself in contact with the regional representative, or they may be conducted at the regional level, coordinated by the Regional Representatives. In addition, statewide peer reviews are generally held twice/year in conjunction with MAWS conferences.

The Incident Review Process (IRP) is a procedure by which to review the process of care leading to a particular outcome ("sentinel event"). The IRP is designed to be a supportive process through which midwives hear constructive feedback regarding their own procedures and practice guidelines and the general standards of care in the community.

The QMP committee is a volunteer group of professional MAWS members, which meets regularly to track peer review reports, via a summary submitted with ideas for continuing education, and to review midwives' self-reported incidents and /or complaints from clients, providers, family members, or the general public. If a self-report or a complaint meets criteria and warrants review, the QMP committee organizes a panel to review the case and report their findings and recommendations to the committee. The committee then interprets and summarizes those findings to the midwife, and in some cases asks that the midwife submit recommended revisions of policies or practice guidelines, attend continuing education on particular topics, and/or organize additional peer reviews beyond what is required by MAWS (or the JUA). Rarely, the committee may be obligated to report certain situations to the Department of Health, according to guidelines in the document.

As a MAWS professional member, each midwife agrees to: 1) participate as a panelist on an Incident Review Panel when called upon to do so, 2) maintain strict confidentiality whenever participating in Peer Review or on an Incident Review Panel, 3) turn in a self-report within 14 days if any of the "sentinel events" occur.

For more information about the Quality Management Program, a list of "sentinel event criteria", or access to the "self-report" or complaint form, visit www.washingtonmidwives.org/maws-qmp.shtml.

Resources for Getting Started

NPI (National Provider Identifier) Number

A National Provider Identifier (NPI) is required in order to contract with insurance companies, set up lab contracts, etc. NPIs are free and easy to obtain through the NPI website: www.nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart.

The midwife taxonomy is 176B00000X.

EIN (Tax ID Number)

Employer identification numbers are an alternative to using your own social security number for your small business. The IRS provides EINs and they are free and easy to obtain online: www.irs.gov/businesses/small/article/0,,id=98350,00.html.

Business Licensing

The Secretary of State provides extensive information about setting up a small business in Washington State at www.dol.wa.gov/business. Don't forget to check your local jurisdiction in case you are required to obtain a local (city/county) business license in addition to your state license.

Medical Supplies

Medical supplies can be purchased online from a variety of sources (just Google "birth supplies") or consider ordering locally from:

- Orion Medical Supply: www.orionmed.com and www.bgms.com
- Cascade HealthCare Products: www.1cascade.com
- Bellegrove Medical Supply: www.bgms.com
- Radiant Belly Supplies for Midwives, Mamas and Babies: www.radiantbelly.com

Resources for Practicing Midwives Physician Consultation

State law states: "It shall be the duty of a midwife to consult with a physician whenever there are significant deviations from normal in either the mother or the infant." (RCW 18.50.010)

Developing relationships with physicians in your local community and region with whom you can consult can sometimes be challenging, but it can also be rewarding. Midwives may consult with family physicians, obstetricians, gynecologists, perinatologists, pediatricians, endocrinologists or other physicians as they see fit. Consultations for significant deviations from normal must be directed to a physician in active obstetrical practice. For other consultations, midwives may discuss a case or refer clients to naturopathic or chiropractic doctors.
MEDCON Education and Referral Service
MEDCON is a toll-free consultation and referral service of the University of Washington (UW) School of Medicine and its academic medical centers, Harborview Medical Center and UW Medical Center. Visit www.uwmedicine.washington.edu/patient-care/referrals/pages/medcon.aspx.

As a major resource for education, medical discovery and patient care, UW School of Medicine places particular importance on its communication with practicing physicians in Washington, Wyoming, Alaska, Montana and Idaho. These interchanges enable the faculty to appreciate the challenges faced by referring physicians in their practices with an eye to providing better assistance and support.

Special operators are available throughout the day to take providers' calls and link them with an appropriate faculty physician with expertise in any particular area. After hours and on weekends, UW Medical Center operators will take your call and connect you with an on-call physician.

Midwives can use this service anytime they have a question regarding patient care and wish to consult with a physician.

Seattle Children's Hospital also has a physician consultation line: Physician-to-Physician Consultation (providers only), 206-987-7777 or 877-985-4637, option 4 (toll-free).

Lab Values for Pregnancy

Many labs in Washington State return values with notations branding the results "high" or "low," but they do not use pregnancy norms for their comparisons. There are many references for normal values in pregnancy, including the following site, which lists many lab tests. Each item is explained and values are listed for men, women, pregnancy, and newborns.

www.brooksidepress.org/Products/Military_OBGYN/Lab/Lab.htm#Hematology

The Importance of Gathering Data and Research

The MANA (Midwives Alliance of North America) Statistics Project

MANA Stats is an important collection of data that assists in analyzing components of midwifery-provided healthcare. All midwives are encouraged to enroll in this important data-collection project. Data collected through MANA stats was used to create the CPM 2000 study — the only prospective trial in North America demonstrating the safety of births at home and in birth centers attended by CPMs. Visit the following link for the full study published in the British Medical Journal in 2005: www.bmj.com/cgi/content/full/330/7505/1416?ehom.

Information about how you can contribute to this important data set to help influence the future of midwifery research and links to the MANA stats contributor enrollment form can be found at: www.manastats.org/help_public_enrolling and twww.manastats.org/docs/EnrollmentForm.pdf.

Resources for Clients

Low-income Client Services
Department of Social and Health Services (DSHS) Pregnancy Medical Program: Pregnancy medical insurance and other benefits for WA State residents who are pregnant and meet income requirements (i.e., once federal qualification levels have been surpassed). Visit www.dshs.wa.gov/onlinecso/pregnancy_medical.shtml.

First Steps Program
www.dshs.wa.gov/onlinecso/first_steps.shtml

Other DSHS Services
www.dshs.wa.gov/onlinecso/services.shtml

WIC (Women, Infants, and Children)
WIC is a nutrition program that helps pregnant women, new mothers, and young children to eat well, learn about nutrition, and stay healthy. WIC is the "Federal Special Supplemental Nutrition Program for Women, Infants and Children." WIC provides health screening, nutrition and health education, breastfeeding promotion and support, and assistance in accessing other services. Provider information about WIC can be found at www.doh.wa.gov/cfh/wic/providers.htm.

Pamphlets and Educational Materials Available Free from the DOH

The Washington State Department of Health has a wide variety of publications available on hundreds of topics, e.g.,

- Pregnancy, Infants, and Children: www.doh.wa.gov/publications/Pregnancy.htm
- Birth Control and Family Planning: www.doh.wa.gov/publications/BirthControl.htm

For all available publications, visit: www.doh.wa.gov/publications/default.htm.

Resources for Charting

Many midwives in Washington State use forms developed by MAWS to chart in a standardized fashion. These forms have been licensed to Cascade Professional Products and are available for purchase at www.1cascade.com/ProductInfo.aspx?productid=2822.

Other midwives use forms developed in the obstetric community, and still others use electronic medical records, including a midwifery-specific EMR called Private Practice: www.getprivatepractice.com.

Any charting method chosen should be comprehensive and used consistently in your practice.

MAWS also maintains transfer forms and other forms designed to facilitate better communication between providers, and to improve standards of care among midwives. These forms are available for download at www.washingtonmidwives.org/clinical-forms.shtml.

Risk-management services are available through the JUA to review charts and recommend areas for improvement.

Continuing education on documentation is available online at www.wsjua.medrisk.com/medrisk/Default.aspx.

Peer review through MAWS also allows midwives an opportunity to conduct chart review with other midwives.

Insurance (Third-Party Payers)/Billing

While many midwives navigate their own billing, there are several companies that will provide this service. To understand more about their processes, please contact them directly. The following are some suggested topics to explore with the company you are considering using:

1. For how many midwives do they currently bill?
2. How long have they been in business?
3. Can they provide two numbers to call as references?
4. What is their process and how long does it typically take to complete?
5. What are their fees?
6. Are they available to speak with clients directly to discuss benefits/coverage and billing questions?

There are a variety of companies that specifically handle billing for midwifery practices. Contact some established midwives in your area and ask who they are using. This will help you compile a short list of companies to interview.

- Available services include (but may not be limited to):
- Especially Births Billing Service: www.EspeciallyBirths.com
- Larsen Billing: www.larsenbilling.com
- Midwife Billing and Business: www.midwifebilling.com
- Victoria Malloy-alternative Medical Billing, LLC: (206) 932-0870
- Ingrid Skjelstad: (360) 321-5370

Credentialing and Contracting

Credentialing and contracting are two separate, but sometimes combined, processes administered by third-party payors (health insurance companies). Credentialing is the process by which your education and license are vetted by a third-party payor. Contracting is the process of establishing a contract with an insurance company so that you may provide services to their clients as an in-network (preferred) provider.

The Washington Practitioner Application is used by several third-party payors for credentialing in Washington State; it is a standardized form used across the state that collects information about your background, training and work experience. In addition, there are two organizations — CAQH and OneHealthPort — now providing centralized (mostly electronic) credentialing services, but few insurance companies are actually using them, so the process of completing a handwritten or typed application continues. Each insurance company provides credentialing/contracting information/instructions on their website. You can call each company and ask if they participate in OneHealthPort or CAQH, and/or what their preferred process is for credentialing. They will likely require your NPI, EIN (or SSN), and DEA number if you have one. They may also ask for a hospital affiliation, or the name of a hospital that participates in their network. There is some lag on the part of insurance companies in recognizing that licensed midwives are independent practitioners in Washington State, and you may need to get a letter from your hospital indicating that they will accept your transfers. Some companies prefer to classify you as a CNM or CM since their systems presumably do not have any other way to categorize a Licensed Midwife.

A law in WA State, commonly referred to as the "every category of provider" law, ensures that health insurance companies based in WA contract with LMs provided they contract with physicians to provide primary maternity care services to their members. As a result, most insurance companies will accept new applications from LMs who wish to join their networks. Some insurance companies, however, may say they do not need any additional providers in a given geographic region at any given time. In such cases, you may wish to inquire about a waiting list, or ask when you might call back again. A few insurance companies (such as those carried by some federal employees) are able to maintain a national exemption from our state law and may refuse to contract with LMs. If this is the case, clients can appeal to their insurance company for an exemption. In the future, if CPMs gain federal recognition as Medicaid providers, access to these additional third-party networks may be more readily available.

Major insurance companies in Washington State include the following:

1. Regence (recently acquired Uniform) — 800-562-2156, may also be referred to as Blue Cross Blue Shield.
2. Cigna (Great West) — (800)-882-4462.
3. Aetna.
4. Premera (including Lifewise) — (800)213-5470, may also be referred to as Blue Cross Blue Shield.

5. First Choice Health Network — (800)-231-6935.
6. Group Health — (888)767-4670, may also be referred to as Healthy Options.
7. Molina (a DSHS provider) — (800) 869-7165. You must become a planned home birth provider with DSHS prior to applying.
8. Community Health Plan of Washington (a DSHS provider), CHPW — 800-440-1561.
9. DSHS — (800)-562-3022 is not an insurance company, but you will want to apply to accept clients who have DSHS open coupons (which means they have not been assigned a DSHS managed-care provider).
10. United — (877) 842-3210.

Most insurance companies require:

1. Washington Practitioner Application (WPA) — You can download a digital copy of the WPA and fill it out using Microsoft Word. Then, you are able to simply change the insurance company's name on the title page for your various applications. It is also possible to export the Word document you have created into an Adobe PDF, then print it out, email it or fax it for each application. WPA downloads are available from most companies that require them, including: www.fchn.com/ppo/providers/WAPractitionerApplication.aspx.
2. All current state licenses.
3. Current Professional Liability Insurance Policy Face Sheet (e.g., from the JUA).
4. W9 (Request for Taxpayer Identification Number and Certification).
5. DEA license (if applicable).
6. CPR and NRP cards.
7. Current Plan for Consultation, Emergency Transfer, and Transport Form — Available for download at: www.doh.wa.gov/hsqa/professions/midwifery/forms.htm or www.doh.wa.gov/hsqa/professions/midwifery/documents/679-121.pdf.

One Health Port is located at www.onehealthport.com — Provider Management (ProviderSource). Once you've filled out the application (identical to the Washington Practitioner Application), you can make your application available to the participating insurance companies. You may also need to alert the company that your application is now available. CAQH is at www.caqh.org. In order to access CAQH, you must call one of the participating companies and ask to be added to the CAQH roster. Aetna and Cigna are the major participants in Washington.

Credentialing can be a long, frustrating process. Keep a detailed file or spreadsheet of each contact you have, the phone number you called, the phone tree options you selected, the information that was requested, when you sent it, etc. Keeping scanned copies of your licenses, face sheets, W9s, etc, can make the process a lot easier, especially if you use an online fax program (like MyFax.com), as you can assemble faxes with these attachments much more easily than you could fax paper copies. Be sure to respond to requests in a timely manner, as many payors have time limits within which they expect a reply or you will have to start the process over again.

Getting Started:

Apply for a DSHS Medicaid Provider Number immediately. This process sometimes takes many months. To help expedite the process, you can e-mail a priority enrollment request to:providerenrollment@dshs.wa.gov

Put "Priority Request" in the subject header and make a case for why you should get your approval ASAP (like you work in an underserved county!). Not sure yet if this makes a difference, but it can't hurt.

www.hrsa.dshs.wa.gov/ProviderEnroll/New%20Provider.htm

At the same time, Download the following piece of paper and fax it to Jean Gowan at the DOH along with a copy of your W-9. This will add you to the list of Home and Birth Center providers approved by the state

www.hrsa.dshs.wa.gov/ProviderEnroll/licensed%20midwives.pdf

Spend a couple of hours completing ONE Washington ProviderApplication (you can download a copy here: www.pacificsource.com/provider/washington/credentialing-application.pdf.) You can submit this application for Regence and Premera.

Handy tip. Download a trial version of BlueBeam PDF.http://www.bluebeam.com/web07/us/downloads/standard/

It's free for a month and you can type up these applications and save them as PDF. Use this time to make your Informed Consent docs into PDF's too.

Some insurance companies are currently requiring formal written collaborative agreements with a physician at your closest hospital or a physician reference letter as one of their criteria for contracting. Obviously this can be difficult to obtain as a new provider. Start developing relationships with physicians in your area right away. You may find that family physicians, hospitalists, gynecologists, pediatricians and perinatologists are particularly open to consulting with you because they consult with other providers regularly. If you have difficulty getting credentialed and contracted with some insurance companies, your clients may be able to request a referral from their PCP's for an OOH birth with you if their are few midwives in your area with contracts.

It's probably also a good idea to attach some extras to the applications; copies of your license, NRP, CPR cards, JUA cover sheet , AND MAWS Indications for Consultation… doc. MAWS Home to Hospital Transfer Guidelines as well as a PERSONAL COVER LETTER. Go the extra mile to look the consummate professional.Arbus may make a difference when your application is picked up for review.

Once you're credentialed, you can then sign a contract with the company. Companies will typically provide a sample fee schedule when asked. Some companies have you sign a contract first, then send you a countersigned contract after they've credentialed you. Keep a spreadsheet of when you were approved. You can also search for yourself on the company's website to see if you're listed as a network provider.

The Regulation of Midwifery in WA

The Washington (WA) State Department of Health (DOH) regulates health professions with the "exclusive purpose of protecting the public interest" when it is determined that:

- "Unregulated practice can clearly harm or endanger the health, safety, or welfare of the public, and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument"; and when
- "The public needs and can reasonably be expected to benefit from an assurance of initial and continuing professional ability." (RCW 18.120.010) http://apps.leg.wa.gov/RCW/default.aspx?cite=18.120.010

It was determined by the Washington State legislature that "any person who shall practice midwifery in this state after July 1, 1917, shall first obtain…a license so to do." Statute also provides the DOH with some guidance about the "examination of the applicant" they mush conduct before granting such a license. (RCW 18.50.020)

According to RCW 18.50.040, applicants can demonstrate that they have "received a certificate or diploma from a midwifery program accredited by the secretary and licensed under chapter 28C.10 RCW [see below for approved schools], when applicable, or a certificate or diploma in a foreign institution on midwifery of equal requirements conferring the full right to practice midwifery in the country in which it was issued."

Washington statute goes on to explain why the state is in the business of approving or accrediting midwifery schools. "The secretary provides for accreditation of midwifery educational programs for the following reasons":

- To ensure that only qualified midwives will be licensed to practice in the State of Washington.
- To ensure the safe practice of midwifery by setting minimum standards for midwifery educational programs that prepare persons for licensure as midwives.
- To ensure that each midwifery educational program has flexibility to develop and implement its program of study and that it is based on minimum standards for accredited schools of midwifery provided herein.
- To ensure that standards for each accredited midwifery program promote self evaluation.
- To assure the graduates of accredited schools of their eligibility for taking the licensing examination for midwives. (WAC 246-834-090)

Statute does, however, also allows for midwives who have not attended a state-approved school to apply for licensure. WAC 246-834-065 outlines the requirements that must be met by these applicants:
http://apps.leg.wa.gov/WAC/default.aspx?cite=246-834-065.

We refer to the application process that any person who has not attended a state-approved school must go through as the Washington State Challenge Process for Midwifery Licensure. More information and details about that process are provided in a separate manual titled The Washington State Challenge Process for Midwifery Licensure: A Manual for Applicants Who Have Not Attended a Washington State-Approved School.

Midwifery Advisory Committee (MAC)
The Washington State Department of Health has a Midwifery Advisory Committee (MAC). This committee is composed of professionals from the state, midwives and physicians, as well as a consumer. They are responsible for the profession of midwifery as it relates to the state, including reviewing all complaints against licensed and unlicensed midwives that are filed. For more information, visit:
www.doh.wa.gov/hsqa/Professions/midwifery/committee.htm.

Continuing Education

Continuing education is considered an important tool for helping healthcare providers maintain competence in their field and expand their knowledge of new and emerging data, best practices and standards of care.

For information about continuing education opportunities offered by MAWS and other local and national organizations, visit the MAWS website at www.washingtonmidwives.org/external-events.shtml.

The MEAC website has an ongoing calendar of continuing education opportunities approved for CEUs. Visit: www.meacschools.org/approved_courses.php.

For a list of courses offered at Bastyr University and the Simkin Center for Allied Birth Vocations (formerly Seattle Midwifery School) near Seattle, visit: www.seattlemidwifery.org/simkin-school/simkin-schedule.html.

For a list of courses offered at Birthingway College of Midwifery in Portland, OR, visit www.birthingway.edu/community/workshops.htm.

For information about upcoming Midwives Alliance of North America (MANA) conferences, visit www.mana.org/conf.html.

For information about upcoming Midwifery Today Conferences, visit: www.midwiferytoday.com/conferences.

For information about upcoming events sponsored by the Canadian Association of Midwives, visit: www.canadianmidwives.org/CAM-conference.html.

Distance Options for Continuing Education: PESI HealthCare:
www.pesihealthcare.com
www.avivainstitute.org

Online Resources for Midwives:

Research and Core Documents

- Recent Evidence & Publications — www.washingtonmidwives.org/evidence-based-care.shtml
- CPM Issue Brief — www.mana.org/pdfs/CPMIssueBrief.pdf
- Milbank Report — www.childbirthconnection.org/pdfs/evidence-based-maternity-care.pdf
- WA DOH Cost Benefit Analysis Study — www.washingtonmidwives.org/assets/Midwifery_Cost_Study_10-31-07.pdf
- CPM 2000 Study — www.bmj.com/cgi/content/full/330/7505/1416?ehom
- MANA's Statement on Reforming Maternity Care in America — www.washingtonmidwives.org/assets/MANA-Reforming-Maternity-Care.pdf
- National Perinatal Association's Statement on Midwifery — www.nationalperinatal.org/advocacy/pdf/Midwifery.pdf
- American Public Health Association's Midwifery Statement — www.globalmidwives.org/files/APHA_Resolution.pdf

National Midwifery Organizations

- MANA — www.mana.org
- NACPM — www.nacpm.org/
- NARM — www.narm.org
- MEAC — www.meacschools.org/
- CfM — www.cfmidwifery.org/index.aspx
- ICTC — www.ictcmidwives.org/
- ACNM — www.acnm.org/
- Canadian Association of Midwives — www.canadianmidwives.org
- Big Push for Midwives Contact Info — www.thebigpushformidwives.org/index.cfm/fuseaction/home.contact/index.htm
- New Zealand College of Midwives — www.midwife.org.nz/
- Australian College of Midwives — www.midwives.org.au/
- Royal College of Midwives (UK) — www.rcm.org.uk/
- Homebirth Association of Ireland — www.homebirth.ie/midwiferytraining&practice.htm

Local Midwifery Organizations

- MAWS — www.washingtonmidwives.org
- California Association of Midwives — www.californiamidwives.org/
- Midwives' Association of British Columbia — www.bcmidwives.com
- College of Midwives of BC — www.cmbc.bc.ca
- Association of Ontario Midwives — www.aom.on.ca
- College of Midwives of Manitoba — www.midwives.mb.ca
- The Alberta Association of Midwives — www.alberta-midwives.com/index.php
- Oregon Midwifery Council — www.oregonmidwiferycouncil.org/OMC/Welcome.html

International Midwifery Organizations

- ICM — www.internationalmidwives.org

Consensus Statements/Position Statements by Midwifery Organizations

- MANA Position Statements — www.mana.org/positions.html
- NZCOM — www.midwife.org.nz/index.cfm/1,108,html
- RCM — www.rcm.org.uk/college/standards-and-practice/position-statements
- CAM on Normal Birth — www.canadianmidwives.org

Appendix A: MAWS Indications for Discussion, Consultation and Transfer of Care in an Out-of-Hospital Midwifery Practice (April 2008)

1. Introduction:

Licensed midwifery, as defined in RCW 18.50, is an autonomous profession. Licensed midwives work interdependently with one another and with other health care practitioners to promote the optimal health and safety of low-risk mothers and babies during the normal childbearing cycle. When there are significant deviations from normal during the pregnancy, labor, or postpartum period, licensed midwives are required by law in Washington State (RCW 18.50.010) to consult with a physician regarding the client's care.

Licensed midwives engage in an ongoing screening process that begins during the initial visit and continues through the completion of care in the postpartum period. In providing care, licensed midwives take into account their client's own informed choices, the state laws and regulations, the standards for practice and core competencies for basic midwifery care provided by their professional organizations, the midwifery and medical literature, the settings in which they practice, the collaborative relationships they have with other health care practitioners and area hospitals, and their clinical judgment, expertise, and philosophy of care.

During pregnancy, labor, or postpartum, risk factors or complications can develop. This document provides a list of conditions that a licensed midwife may encounter in practice for which discussion, consultation, or transfer of care is indicated. The list is representative but not exhaustive. Other circumstances may arise where the licensed midwife believes discussion, consultation, or transfer of care to be necessary.

Professional members of the Midwives' Association of Washington State (MAWS) discuss, consult, and/or transfer care of their clients according to this document and in accordance with the MAWS document Position Statement: Shared Decision-Making. In addition, new clinical procedures may be undertaken in accordance with the MAWS document Mechanism for Introducing Expanded Clinical Procedures into Midwifery Practice. MAWS members should discuss the scope and limitations of midwifery care with clients and refer to these documents as necessary.

This document should be used as a screening tool to distinguish between low-risk and higher-risk maternal and newborn clients. Its purpose is to enhance safety and promote licensed midwives' accountability to their clients, to one another, to other health care practitioners, and to the general public. MAWS reviews this document every two years and revises it as necessary in order to reflect the most current evidence available and to insure that the parameters identified promote the safety of mother and infant without unduly restricting midwifery practice. To that end, in writing this document MAWS has sought guidance from midwifery documents from countries with well functioning, integrated midwifery systems (Canada, the Netherlands, and Australia).

2. Definitions:

2.1 DISCUSSION WITH ANOTHER MIDWIFE, AN ARNP, OR A PHYSICIAN

A discussion refers to a situation in which the midwife seeks advice or information from a colleague about a clinical situation, presenting her management plan for feedback.[1]

2.1.1 It is the midwife's responsibility to initiate a discussion with and provide accurate and complete clinical information to another midwife, a nurse practitioner, or a physician in order to plan care appropriately. This discussion can take place between midwives in the same practice.

2.1.2 Discussion should occur in a timely manner soon after the clinical situation is discovered.

2.1.3 Discussion may occur in person, by phone, fax, or e-mail.

2.1.4 Discussion may include review of relevant patient records.

2.1.5 Discussion may include request for prescriptive medication based on signs or symptoms and/or laboratory results.

2.1.6 Discussion should be documented by the midwife in her records. Documentation of discussion should refer only to practitioner type without specifying the name of the practitioner contacted. Documentation should also include the midwife's

1 A MAWS member who has additional credentials (i.e.: CNM, ND) that allow for a broader scope of practice need not discuss conditions which are within her scope of practice.

management plan.

2.1.7 Discussion need not occur if the midwife has previously encountered a particular situation, discussed it with a colleague, developed a management plan, and is currently managing the same clinical presentation. In this case, documentation of the management plan and discussion with the client of the management plan is sufficient.

2.2 CONSULTATION WITH A PHYSICIAN

A consultation refers to a situation in which the midwife, using her professional knowledge of the client and in accordance with this document, or by client request, seeks the opinion of a physician competent to give advice in the relevant field. The consultant will either conduct an in-person assessment of the client or will evaluate the client's records in order to address the problem that led to the consultation.

2.2.1 It is the midwife's responsibility to initiate a consultation and to communicate clearly to the consultant that she is seeking a consultation.

2.2.2 A consultation can involve the physician providing advice and information, and/or providing care to the woman/newborn, and/or prescribing treatment for the woman or newborn.

2.2.3 In the case of an in-person consultation, the midwife should expect that the consultant will promptly communicate findings and recommendations to the client and the referring midwife after the consultation has taken place.

2.2.4 Where urgency, distance, or climatic conditions do not allow an in-person consultation with a physician when it would otherwise be appropriate, the midwife should seek advice from the physician by phone or other similar means. The midwife should document this request for advice in her records and discuss the consultant's advice with the client.

2.2.5 It is the midwife's responsibility to provide all relevant medical records to the consultant, including a written summary of the client's history and presenting problem, as appropriate.

2.2.6 Consultation must be fully documented by the midwife in her records, including the consultant's name, date of referral, and the consultant's findings, opinions, and recommendations. The midwife must then discuss the consultant's recommendations with the client.

2.2.7 After consultation with a physician, care of the client and responsibility for decision- making, with the informed consent of the client, either continues with the midwife, is shared collaboratively by the midwife and the consultant,[2] or transfers completely to the consultant. Transfer or sharing of care should occur only after dialogue and agreement among the client, the midwife, and the consultant.

2 During such collaborative care the consultant may be involved in, and responsible for, a discrete area of the client's care, with the midwife maintaining overall responsibility within her scope of practice. It is the midwife's responsibility to maintain explicitly clear communication between all parties regarding which health professional has primary responsibility for which aspects of the client's care. In addition to any verbal dialogue regarding client care, the midwife should confirm the management plan in writing, and both the client and consultant should receive a copy.

3. Indications:

3.1 PRE-EXISTING CONDITIONS AND INITIAL HISTORY

Discussion:

- family history of significant genetic disorders, hereditary disease, or congenital anomalies
- history of pre-term birth (< 36 weeks)
- history of IUGR
- history of severe postpartum hemorrhage
- history of severe pre-eclampsia
- history of gestational diabetes

Consultation:

- history of uterine surgery, including: myomectomy, hysterotomy, or prior cesarean birth
- current or significant history of cardiovascular disease, renal disease, hepatic disorders, neurological disorders, severe gastrointestinal disease
- current or significant history of endocrine disorders (excluding controlled mild hypothyroidism)
- pulmonary disease/active tuberculosis/asthma if severe
- collagen-vascular diseases
- significant hematological disorders
- current or significant history of cancer
- history of cervical cerclage
- history of 3 consecutive spontaneous abortions
- significant uterine anomalies
- essential hypertension
- history of eclampsia or HELLP
- previous unexplained neonatal mortality or stillbirth
- isoimmunization with an antibody known to cause hemolytic disease of the newborn
- history of postpartum hemorrhage requiring transfusion
- current severe psychiatric illness
- no prenatal care prior to third trimester
- current or history of epilepsy

Transfer:

- absent prenatal care at term
- any serious medical condition, for example: cardiac disease, renal disease with failure, insulin-dependent diabetes mellitus, or uncontrolled asthma 3. Indications:

3.2 ANTEPARTUM CONDITIONS

Discussion:

- urinary tract infection unresponsive to treatment
- significant abnormal ultrasound finding
- well-controlled gestational diabetes
- persistent size/dates discrepancies

Consultation:

- significant abnormal Pap
- thrombosis
- fetal demise after 14 weeks gestation
- persistent anemia, unresponsive to treatment
- primary herpes infection
- significant vaginal bleeding
- premature pre-labor rupture of membranes (PPROM)
- isoimmunization, hemoglobinopathies
- persistent abnormal fetal heart rate or rhythm
- significant placental abnormalities
- documented intrauterine growth restriction
- unresolved polyhydramnios or oligohydramnios
- significant infection the treatment of which is beyond the midwife's scope of practice
- 42 completed weeks with reassuring fetal surveillance
- presentation other than cephalic at 37 weeks
- significant abnormal breast lump
- pyelonephritis
- ectopic pregnancy
- molar pregnancy

Transfer:

- multiple gestation
- persistent transverse lie, oblique lie, or breech presentation
- persistent hypertension, HELLP, pre-eclampsia, or eclampsia
- placenta previa at term
- clinically significant placental abruption
- cardiac or renal disease with failure
- uncontrolled gestational diabetes
- known fetal anomaly or condition that requires physician management during or immediately after delivery

3.3 INTRAPARTUM CONDITIONS

In certain intrapartum situations, the midwife may need to act immediately and transport may not be the most prudent course of action in that moment. It is expected that the midwife will use her clinical judgment and expertise in such situations, access 9-1-1 if appropriate, and then transport if and when it becomes necessary.

Discussion:

- arrested active phase of labor (>6 hours of regular, strong contractions without any significant change in cervix and/or station and/or position)
- arrested 2nd stage of labor (>3 hours of active pushing without any significant change)
- prolonged rupture of membranes (>48 hours)

Transfer:

- labor before 37 weeks
- transverse lie, oblique lie, or breech presentation
- multiple gestation
- sustained maternal fever (>100.4 F) or other evidence of maternal infection
- moderate or thick meconium
- persistent non-reassuring fetal heart rate pattern
- maternal exhaustion unresponsive to rest/hydration
- abnormal bleeding during labor
- suspected placental abruption
- suspected uterine rupture
- persistent hypertension
- pre-eclampsia
- maternal seizure
- ROM >72 hours or ROM >18 hours with unknown GBS status and no prophylactic antibiotics or GBS+ and no prophylactic antibiotics
- prolapsed cord or cord presentation
- significant allergic response
- active genital herpes in vaginal, perineal or vulvar area in labor or after ROM
- client's clear desire for pain relief or hospital transport

3.4 POSTPARTUM CONDITIONS

Discussion:

- urinary tract infection unresponsive to treatment
- mastitis unresponsive to treatment
- subinvolution

Consultation:

- breast abscess
- retained products/unresolved subinvolution
- sustained hypertension
- significant abnormal Pap
- postpartum depression

Transfer:

- significant postpartum hemorrhage unresponsive to treatment, with or without sustained maternal vital sign instability or shock
- retained placenta (>1 hour or active bleeding and manual removal unsuccessful)
- lacerations beyond midwife's ability to repair
- unusual or unexplained significant pain or dyspnea
- significant hematoma
- endometritis
- postpartum psychosis
- maternal seizure
- anaphylaxis
- persistent uterine prolapse or inversion

3.5 NEWBORN CONDITIONS

It is strongly recommended that all newborns be seen by an appropriate pediatric provider by 2 weeks of age. The following conditions warrant contact sooner.

Discussion:

- lowbirthweightinfant(<2500gm = 5lbs8oz)
- loss of greater than 10% of birth weight

Consultation:

- persistent cardiac arrhythmias or murmurs
- significant clinical evidence of prematurity
- failure to thrive
- hypoglycemia
- significant jaundice in first 24 hours or pathologic jaundice at any time

Transfer:

- seizure
- persistent respiratory distress
- persistent central cyanosis or pallor
- persistent temperature instability
- persistent hypoglycemia
- Apgar score less than 7 at five minutes of age and not improving
- major apparent congenital anomalie
- birth injury requiring medical attention

Appendix B: The Challenge Process Route to Licensure

Applicants who have not attended a state-approved school and who are seeking licensure through the WA State challenge process have long requested clarification about how to meet the state's requirements. While the details are outlined in statute (WAC 246-834-065), applicants have understandably requested guidance about what details they should provide as part of their application. Many applicants have even requested information and clarity prior to choosing a midwifery school or before beginning an apprenticeship to help ensure they are on the right track as they seek to meet the state's requirements. At the same time, those receiving and evaluating these applications have asked for guidance because, without a frame of reference, it has been difficult to determine whether challenge process applicants have, in fact, met the state's requirements.

An existing handout developed by the DOH reads "foreign graduates, and applicants applying for credit toward educational requirements need to supply more information regarding their program and cause their school to provide information so that it can be determined if they are of equal requirements. Foreign applicants must also have proof of their licensure in the foreign jurisdiction sent directly from the agency from which it was issued. Credit toward educational requirements for licensure of unlicensed midwives will be considered on a case by case basis. Existing rules are used to make a determination." (SOURCE: www.doh.wa.gov/hsqa/professions/midwifery/documents/CredReqs.pdf)

Understanding the requirements that must be met by state-approved schools will better enable an applicant to demonstrate how their program/diploma/certificate meets "equal requirements." Existing statute details the curriculum requirements of state-approved schools. (WAC 246-834-140 www.apps.leg.wa.gov/WAC/default.aspx?cite=246-834-140)

In particular, "Each school must ensure that the students receive instructions in the following instruction area:

a. Instruction in basic sciences (including biology, physiology, microbiology, anatomy with emphasis on female reproductive anatomy, genetics and embryology) normal and abnormal obstetrics and gynecology, family planning techniques, childbirth education, nutrition both during pregnancy and lactation, breast feeding, neonatology, epidemiology, community care, and medicolegal aspects of midwifery.

b. Instruction in basic nursing skills and clinical skills, including but not limited to vital signs, perineal prep, enema, catheterization, aseptic techniques, administration of medications both orally and by injection, local infiltration for anesthesia, venipuncture, administration of intravenous fluids, infant and adult resuscitation, and charting.

c. Clinical practice in midwifery which includes care of women in the prenatal, intrapartal and early postpartum periods, in compliance with RCW 18.50.040." (WAC 246-834-140)

Because the DOH is currently using existing rules to determine if applicants have met the educational requirements for licensure, the Midwives' Association of WA State (MAWS) thought it would be helpful to clarify details about the national Certified Professional Midwife (CPM) credential that many applicants are obtaining prior to applying for WA State licensure. The DOH determines what additional requirements must be met by these particular applicants to achieve licensure in WA State.

Additional Requirements for CPMs Applying for Midwifery Licensure in WA State Who Have Not Attended a State-Approved School

Washington State has some additional requirements for all applicants who have not attended a state-approved school, regardless of the route by which they earned their CPM. They include:

- 30 additional observed births.
- 30 additional births in which the applicant is managing the births.
- 10 additional postpartum exams.
- AIDS Training: www.doh.wa.gov/cfh/hiv/prevention/training/default.htm.
- An application that demonstrates that they have "completed a program preparing candidates to practice as a midwife provided such program is equivalent to the minimum course requirements of approved midwifery programs in Washington at the time of applicant's program completion" OR that they have "a certificate or diploma in a foreign institution on midwifery of equal requirements."

The fifth bullet point above can be a source of confusion for applicants. Although the language comes directly from WA State statute, applicants have regularly asked for clarity as they seek to understand the requirements they must fulfill. At present, applicants must demonstrate how the program they attended and/or the certificate or diploma they received provided them with the equivalent training received by graduates who attended state-approved schools during the same time frame.

Understanding the requirements that must be met by state-approved schools will better enable an applicant to demonstrate how their program/diploma/certificate meets "equal requirements." Existing statute details the curriculum requirements of state-approved schools (WAC 246-834-140 www.apps.leg.wa.gov/WAC/default.aspx?cite=246-834-140), as well as the conditons that must be met by applicants. (RCW 18.50.040 www.apps.leg.wa.gov/rcw/default.aspx?cite=18.50.040)

At this point in time, no more specific information is provided by the state about which programs or schools or curricula meet "equal requirements." However, courses offered at MEAC accredited and/or regionally accredited schools have been vetted by third party accreditation agencies. In academia in general, accreditation is considered to confer value because these schools have elected to make their policies and curricula transparent and to be held accountable to clearly defined standards. MEAC accredited and regionally accredited schools have their curricula evaluated and verified by a third party agency which is itself overseen by the US Department of Education.