2017 Task Analysis

A Report of Midwifery Practice

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FORWARD TO THE 2017 TASK ANALYSIS OF MIDWIFERY PRACTICE

AMCB is pleased to release the 2017 Task Analysis Report of Midwifery Practice.

The Institute for Credentialing Excellence (ICE) created the National Commission for Certifying Agencies (NCCA) in 1987. NCCA establishes the standards for accreditation of certification programs and requires a "task analysis or "job analysis" which serves as the basis of the initial examination for certification as a nurse-midwife (CNM) or midwife (CM). The NCCA periodically updates requirements, but this analysis is consistently a critical part of the requirements. In 2016, it can be found under Standard 14 in the NCCA Self-Assessment Checklist. The task analysis provides the guide for the development of the exam blueprint (http://www.credentialingexcellence.org/p/cm/ld/fid=87 Last accessed 3/2/2017).

The Task Analysis of Midwifery Practice, conducted by AMCB, and the American College of Nurse-Midwives (ACNM) Core Competencies are separate mechanisms and activities. The Task Analysis is conducted by AMCB and is determined by a comprehensive survey of newly certified CNMs/CMs and their report of the tasks they are performing. The Task Analysis is used to guide development of the AMCB certification exam. The ACNM Core Competencies are developed by expert opinion of necessary knowledge and competencies to be included in midwifery education curricula. The ACNM Core Competencies are used to guide educational program curriculum development. The two activities are intertwined, but distinct and both are critical for the education and certification of safe and competent health care providers.

Following completion of the Task Analysis, recommendations are made to the AMCB Board of Directors for items to be considered for retention or elimination in the examination blueprint. The AMCB Board of Directors considers these recommendations, and makes the final decision. This decision is then passed on to the AMCB Examination Committee to be incorporated into the new examination blueprint.

There is no defined timeline for a task/job analysis, but AMCB conducts one every five years. NCCA notes that it is important that there be a time frame and process and notes that certification bodies typically perform a task analysis every five to seven years (http://www.credentialingexcellence.org/p/cm/ld/fid=100, last accessed 3/2/2017). AMCB aims to complete their analysis every five years, just prior to the scheduled revision of the ACNM Core Competencies. This will allow the ACNM Core Competencies to reflect the current practices of newly certified CNMs/CMs, complementing the input of educational experts, who are charged with the revisions of the ACNM Core Competencies and future curricula.

The Board of Directors of AMCB thanks the AMCB Research Committee, led by Barbara McFarlin, CNM, PhD, RDMS, FACNM, FAAN and Tanya Tanner, PhD, MBA, APRN, CNM, FACNM for their thoughtful review and timely execution of the task analysis process and the report that follows.

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A BRIEF HISTORY OF THE AMERICAN MIDWIFERY CERTIFICATION BOARD

The American Midwifery Certification Board (AMCB), formerly the ACNM Certification Council, Inc. (ACC) serves as the national certifying body for Certified Nurse-Midwives (CNMs) and Certified Midwives (CMs) in the United States. The organization has a long history of setting high standards for professional midwifery practice through a rigorous credentialing process that includes completion of an Accreditation Council for Midwifery Education (ACME) accredited nurse-midwifery or midwifery program, successful performance on the national board examination, and documented continuing competency through the certificate maintenance program.

Certification of nurse midwives began in 1971. The examination was initially administered through the ACNM Testing Committee, which developed into the Division of Examiners, then became the Division of Competency Assessment, and finally emerged as an autonomous organization, the ACNM Certification Council, Inc., in 1991 and renamed American Midwifery Certification Board (AMCB) in 2005. The process and scope of certification has grown as midwifery practice has evolved and as the organization has kept pace with the changes and expectations of the credentialing organizations and the health care field.

Initially, certification was limited to Certified Nurse-Midwives. However, as midwifery practice has developed, a demand for "direct-entry" (non-nurse midwifery) programs has intensified. In 1996, committed to the principle that all midwifery practice should meet the same high standard that nurse-midwifery established, the AMCB, in conjunction with the ACNM, developed a mechanism for the accreditation of professional, university-based direct-entry midwifery education programs and the certification of those graduates. Accreditation criteria for direct-entry programs are the same as for nurse-midwifery programs. Graduates of a direct-entry program take the same certification examination as those from nurse-midwifery programs and are awarded the Certified Midwife (CM) credential.

In addition to broadening the scope of certification to professionally educated direct-entry midwives, the AMCB has added a program in certification maintenance. Initial certificates in nurse-midwifery were not time-limited. Although there was a professional expectation that CNMs would continue to learn and to maintain currency in their practice, their certificates did not expire and there was no documentation of continued competence by AMCB. In 1996, the AMCB began to issue time-limited certificates and mandated participation in its Certificate Maintenance Program for all CNMs and CMs certified after that date. In 2011, AMCB began requiring all certificants to meet recertification requirements. During a five-year cycle, certificants must complete three self-learning modules (including post-tests) that cover the entire scope of midwifery practice. In addition, they must accrue 20 contact hours of approved continuing education.

The nature of the national board examination has also changed. From 1971 through 1995, the certification examination was in a modified essay format. Furthermore, for the first three years, a clinical observation component was included. Analysis indicated that the clinical observation did not provide data that would change the outcome of the written component and in 1974 it was eliminated from the certification requirements. In 1988, a change was made from norm-referenced to criterion-referenced scoring. The modified essay format performed very well and was continued until 1995 when the increasing number of graduates annually made the arduous task of grading the exams untenable. At that

time, AMCB moved to a multiple-choice format, which has performed very well psychometrically and now allows candidates to obtain results instantly.

A disciplinary process was introduced in the spring of 2000. Prior to the formation of AMCB, the ACNM had an active and effective disciplinary process. When AMCB was incorporated, the disciplinary function remained for a short time with ACNM. ACNM subsequently eliminated its disciplinary process since certification functions had been transferred to AMCB. This allowed AMCB to move forward with their own discipline process. This process is viewed as a mechanism of last resort, when other avenues to address practice concerns have failed. The AMCB Board of Directors is the final arbiter of the grievance. Potential outcomes of an investigation include dismissal of the complaint as well as actions on the certificate up to and including decertification.

Finally, as midwifery has evolved, the content of the examination has continued to reflect the changes in practice. The certification examination has always been grounded in an analysis of the tasks of midwifery. A task analysis has been conducted periodically, typically about every five to seven years, to determine the scope of the examination. In the early 1970s, practice focused heavily upon the traditional scope of midwifery: antepartum, intrapartum, postpartum, and newborn. Minimal content in well-woman care was included, typically annual examination, family planning, and sexually transmitted disease. Gradually, more comprehensive health care of women characterized midwifery practice, requiring the addition of content addressing issues across the life span, including the perimenopausal and menopausal ages.

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EXECUTIVE SUMMARY

The American Midwifery Certification Board (AMCB) conducted a task analysis of the practice of midwifery in an effort to update the certification examination blueprint and subsequent test specifications. The last task analysis was conducted in 2012 and the current task analysis was intended to be a determination of those tasks that are performed by recently certified CNMs and CMs.

The project was conducted by the AMCB Research Committee with support by the Board of Directors. The research team was comprised of both CNMs and CMs and all were members of the AMCB Research Committee. The researchers were all engaged in clinical practice with experience ranging from three to 33 years, and were from five of the seven American College of Nurse-Midwives (ACNM) membership regions. The majority held doctoral degrees and were actively conducting research related to midwifery care. Three of the six researchers had participated in prior AMCB task analyses. All researchers held certification by AMCB. A psychometrician was engaged as a consultant with full participation in the design, analysis and report of the findings of the project.

The task analysis consisted of six phases: 1) development of the questionnaire, 2) piloting the questionnaire in October 2016, 3) identifying the survey population, 4) administration of the questionnaire, 5) data analysis, and 6) dissemination of findings. The 2017 Task Analysis survey instrument was developed by the AMCB Research Committee. Items from the 2012 Task Analysis survey were reviewed for relevance and added or removed to reflect changes in practice and/or terminology. After AMCB Research Committee deliberation, the decision was made to eliminate the clinical conditions section. Clinical conditions are not a part of the content outline of the certification exam template. Eliminating this section shortened the survey, potentially reducing respondent burden and increasing response and completion rates. The resulting initial 2017 Task Analysis survey instrument was approved after several committee revisions, consideration of 2012 Task Analysis questionnaire respondent comments, and review by the AMCB Board of Directors. In addition to CNM/CM demographics, a final list of 241 clinical tasks falling within the six midwifery practice areas: antepartum (n = 45), intrapartum (n = 61),

postpartum (n = 15), newborn (n = 30), well-woman gynecology (n = 59), and primary care (n = 31) were included in the questionnaire.

Clinical tasks were rated by respondents for both frequency of performance in the respondent's midwifery practice, as well competency importance to the practice of midwifery. Each section allowed for respondent comments about the tasks listed in each area of clinical midwifery practice. An unweighted approach was used to determine which of the clinical tasks, if any, would be recommended to the AMCB Board of Directors for elimination from the certification examination blueprint. This was the approach used for the 2012 Task Analysis, as it was determined by Research Committee members that item importance and frequency should be weighted equally. This strategy seemed a reasonable method for exclusion of items based on the pre-determined cutoff value (importance + frequency scores).

A total of 1,744 CNMs/CMs were eligible to take the survey, and 440 CNMs/CMs responded to the questionnaire resulting in a 25% response rate. Complete, usable data were obtained from 348 respondents for a total usable completion response rate of approximately 20%. Respondents had a mean age of 36, most were White, female, CNMs, and had a master's degree. Only six respondents were CMs.

Most respondents (n = 325, 93.4%) indicated that they provided antepartum care, intrapartum care (n = 310, 89.1%), and postpartum care (n = 285, 81.9%). Fewer respondents provided newborn care (n = 65, 18.7%) well-woman gynecology (n = 267, 76.7%), and primary care (n = 111, 31.9%). Items with a combined unweighted score of less than or equal to five were considered for elimination. Decisions about Research Committee recommendations for retention or elimination of individual tasks were reached through consensus. The AMCB Board of Directors then considered these 23 recommended tasks and made the final decision to eliminate 18 of these items across the six domains where one antepartum, four intrapartum, one postpartum, one newborn, six well-woman/GYN, and five primary care tasks were eliminated. Results from this survey provide evidence of the need to reconsider inclusion of 18 tasks in the certification test blueprint. The Research Committee made 11 recommendations for future task analyses.

The mission of the AMCB is to protect and serve the public by assuring that individuals who are credentialed as Certified Nurse-Midwives (CNMs) and Certified Midwives (CMs) have met established standards (AMCB, *n.d.*). Central to that mission is developing and administering a certification examination that determines whether CNMs/CMs have attained the competencies necessary for safe and effective entry-level practice. Results from this task analysis provide data that are crucial to meet this mission.

INTRODUCTION

The American Midwifery Certification Board (AMCB) is responsible for the certification of all Certified Nurse-Midwives (CNMs) and Certified Midwives (CMs) practicing in the United States (US). AMCB is an autonomous body with multidisciplinary and public members responsible for developing and administering a psychometrically sound and legally defensible certification examination to candidates who meet pre-established criteria. With the charge to *protect and serve the public,* AMCB requires all CNMs/CMs to pass a national examination for initial certification. Meeting the pre-established criteria and passing the examination demonstrates that the individual possesses those competencies required to engage in safe entry-level midwifery practice.

To ensure the certification examination has practice-validity and accurately reflects the varied aspects of care provided by midwives, a task (job) analysis must be conducted at least once every five years to ensure that test content specifications accurately reflect current practice (Institute for Credentialing Excellence, 2016). AMCB has previously conducted task analyses for content validation in 2000, 2007 and 2012. The task analysis surveys newly certified CNMs/CMs to ascertain those specific tasks that are performed while providing clinical care. Findings are then used to develop a test blueprint, which provides structure for the certification examination, thus ensuring coverage of the full scope of midwifery practice.

As the profession of midwifery has evolved, the content of the certification examination has continued to reflect changes in practice grounded in the analysis of tasks. The scope of midwifery practice now encompasses the comprehensive health of women across the lifespan, including non-reproductive primary care. With two pathways for eligibility to sit for the AMCB certification examination, AMCB recognizes the importance of the extent to which specific tasks are performed in practice by both CNMs and CMs. The task analysis is integral to ensuring that tasks and the associated knowledge and skills represent the key professional clinical characteristics of midwifery.

PURPOSE/AIMS

A rapidly changing healthcare environment makes knowledge of CNM/CM practice crucial. The purpose of this study was to understand the tasks undertaken in clinical practice by CNMs/CMs newly certified by AMCB for practice in the United States (US). The research aims were to:

1. Identify the frequency and importance of tasks undertaken by CNMs/CMs in the six clinical midwifery practice areas: antepartum, intrapartum, postpartum, newborn, well-woman/ gynecology, and non-reproductive primary care.
2. Determine the extent to which CNMs/CMs provide care to patients with normal versus abnormal conditions.
3. Determine the distribution of tasks for full-scope midwifery practice across the six practice areas for assignment of items in certification examination development.

METHODS

This study was designed as a retrospective survey of all CNMs/CMs certified by AMCB to practice in the US during the preceding three years (September 2013–September 2016).

Research Team

The research team was comprised of both CNMs and CMs and all were members of the AMCB Research Committee. The researchers were all engaged in clinical practice with experience ranging from three to 33 years. They were from diverse U.S. geographic locations, and represented five of the seven American College of Nurse-Midwives (ACNM) membership regions. The majority held doctoral degrees and were actively conducting research related to midwifery care. Five of the six researchers were faculty at Accreditation Commission for Midwifery Education (ACME) accredited CNM/CM educational programs and all served as clinical preceptors for midwifery students or were responsible for midwifery clinical education. Three of the six researchers had participated in prior AMCB task analyses. All researchers were certified by AMCB (Appendix A). A psychometrician was engaged as a consultant with full participation in the project (Appendix B).

Sampling

All prospective CNMs/CMs successfully meeting pre-existing criteria are eligible to sit the AMCB certifying examination after successfully completing their midwifery education. The AMCB certifying examination certifies that successful applicants possess adequate entry-level midwifery knowledge. In keeping with the mission of the certification program and the midwifery population, it was determined by the Research Committee that all graduates of ACME-accredited nurse-midwifery/midwifery programs who achieved certification in the years 2013-2016 and who had not opted-out of participation in research were eligible to participate. This population consisted of 1,744 CNMs/CMs who were identified in the AMCB database (Association Anywhere® - Association Management Software). This database contains e-mail addresses for CNMs/CMs who are certified to practice in the United States.

Ethics

Institutional Review Board (IRB) approval was not sought for the 2017 Task Analysis as the task analysis is considered part of the standard work of AMCB. Ethical considerations were discussed amongst Research Committee members in the absence of IRB approval. Certificants who previously declined to be solicited by e-mail for research were not included in the task analysis process. Incentives were offered to encourage participation, and respondents who successfully completed the survey were awarded 10 contact hours towards AMCB recertification and were eligible to enter a drawing for a chance to win one of 10 gold iPad mini4s.

Survey Development

The 2017 Task Analysis survey instrument was developed by the AMCB Research Committee. Items from the 2012 Task Analysis survey were reviewed for relevance and added or removed to reflect changes in practice and/or terminology. Research Committee members met via web conference twelve times between 2/29/2016 and 6/12/2017 to discuss the design, distribution, and analysis of the survey. An in-person meeting was also held on 10/22/2016 to finalize the project timeline and committee member responsibilities, discuss incentives for respondents completing the survey, review pilot survey comments, and confirm final survey items.

The final Task Analysis survey instrument consisted of a total of 533 items comprising 21 demographic items used to compare characteristics of survey respondents to the AMCB population: eight items to identify the practice areas and sites of each respondent (antepartum, intrapartum, postpartum, newborn, well woman/GYN, and primary care) for purposes of appropriately selecting survey items for each respondent; 241 items of clinical tasks from the six aforementioned midwifery practice areas to be rated by survey respondents for both frequency of use and importance of task; seven items for respondents to suggest tasks and/or practice areas omitted from the survey; three items addressing respondents' opinions about current certification eligibility and recertification requirements; one question regarding percentage of practice spent dealing with abnormal conditions; one item addressing the percentage of certification exam items respondents believe should be assigned to each area of practice; and two questions regarding time spent on the survey completion and item clarity.

Survey respondents were asked to rate each clinical task as to both the frequency that they perform the task and the degree of importance they attribute to the task. Response options and associated scores were as follows: Frequency: "I do not perform this task" (1), "once or twice per year" (2), "quarterly" (3), "monthly" (4), or "daily or weekly" (5); and Importance: "not important" (1), "somewhat important" (2), "important" (3), or "very important" (4). This resulted in the possibility of a maximum unweighted composite score of 9 for each item.

After Research Committee deliberation, the decision was made to eliminate the clinical conditions section that had been included in the previous task analysis because clinical conditions are not a part of the content outline of the test blueprint. Eliminating this section shortened the survey, potentially reducing respondent burden and increasing response and completion rates. The resultant 2017 Task Analysis survey instrument was approved after several committee revisions, consideration of 2012 Task Analysis survey respondent comments, and review by the AMCB Board of Directors.

Pilot Study

Prior to initiating the final 2017 Task Analysis survey process, a pilot study was undertaken. Data collection for this pilot study began on October 13, 2016 and lasted through October 20, 2016. A convenience sample of 25 CNMs/CMs certified prior to September 2013 were invited by e-mail to complete the pilot task analysis questionnaire and provide feedback to

the Research Committee (Appendix C). A total of six midwives completed the survey. Most of the respondent comments were related to the length of time it took to complete the survey. There were also comments related to the overlap between some questions in the postpartum and well-women/gynecological clinical areas. Research Committee members also completed the survey to assess the amount of time needed for completion. The Research Committee subsequently finalized the 2017 Task Analysis survey instrument for dissemination after incorporating relevant suggestions into the final document.

Administration of the Survey

Data collected for the pilot study and the 2017 Task Analysis were collected and managed using REDCap (Research Electronic Data Capture), Version 6.6.2, electronic data capture tools hosted at AMCB headquarters. REDCap is a secure web application designed for building and managing online surveys and databases for research studies. REDCap provides an intuitive interface for validated data entry, audit trails for tracking data manipulations and export procedures, automated export procedures for seamless data downloads to common statistical packages, and procedures for importing data from external sources (Harris et al., 2009).

CNMs/CMs who met the inclusion criteria were sent an initial e-mail invitation from the survey administrator via REDCap inviting them to complete the survey, and a follow-up e-mail reminder after the initial invitation (Appendices D, E). E-mail addresses were obtained from the AMCB certificant database, Association Anywhere®, and imported into REDCap. An e-mail address was considered eligible if the certificant owner met the inclusion criteria and had not previously indicated a desire to opt out of invitations to participate in research. The e-mail invitation provided information about the purpose of the task analysis, instructions for accessing the survey, estimated timeframe for completing the survey, and incentives for participation. Specific instructions for completion of the survey were available after the respondent accessed the survey (Appendix F). The survey was available between November 7, 2016 and November 28, 2016. Participants were given the option to save their responses and return to complete the survey later. Announcements about the task analysis were also disseminated through multiple mediums, including to the Directors of Midwifery Education (DOME), in ACNM *Quick eNews,* on the AMCB website, and on the AMCB Facebook page (Appendices G-K).

ANALYSIS

Data were analyzed using the statistical software package SPSS (version 19) and Microsoft Excel (version 14.6.7). All data were cleaned prior to analysis.

Of the 1,819 CNMs/CMs certified between September 2013 and September 2016, 75 had previously indicated a desire to opt out of participation in research, so were not solicited for participation in the task analysis. 1,744 invitation e-mails were sent, of which 12 were returned or "bounced back." A total of 1,732 were successfully sent and thought to have been received, although it could not be determined if they were read. A total of 440 CNMs/CMs responded to the survey resulting in a response rate of 25.4%. Of the 440 survey respondents, 338 (76.8%) were deemed to have completed the survey as evidenced by clicking the "submit" button at the end of the survey, and 102 (23.2%) were deemed to have not completed the survey as they did not click the "submit" button. Analyses were conducted to assess comparability of the two groups in terms of their demographics, and to compare the survey respondent group to the survey population and the AMCB population. The analyses resulted in the identification of 92 of the 440 surveys (20.9%) that were excluded from the final analysis due to the following reasons:

- Eighteen survey participants completed the demographic questions but did not respond to the remaining questions.
- Twenty-six survey participants completed the demographic questions, partially completed the frequency and importance ratings for the first major domain (i.e., Antepartum), and did not respond to the remaining survey questions.
- Thirty-three survey participants completed the demographic questions and responded "No" to the 6 questions asking if they perform midwifery services for each of the six major domains.
- Fifteen survey participants responded "No" to the question: "Are you currently working as a midwife?"

As a result, complete usable data were obtained from 348 respondents for a total usable completion response rate of approximately 20%. As shown in Table 1, the confidence intervals for the total number of respondents (including completed and incomplete surveys) and the total number of completed surveys used in the final analyses are within acceptable ranges, as they are

less than +/- 5. Tables 2 through 23 contain the responses to the 19 demographic questionnaire items. Participant comments about the survey process are found in Tables 24 through 26. Tables 27 through 30 contain participant opinions regarding requirements for current eligibility for certification and recertification requirements. Responses to clinical tasks are presented in Tables 31 through 36. Free-form comments collected from respondents across each of the 6 clinical practice areas are presented in Appendix L. Appendix M details respondent opinion regarding tasks that should be added to future task analyses.

Evaluation and Retention/Elimination of Clinical Tasks

An unweighted approach was used to determine which of the clinical tasks, if any, would be recommended to the AMCB Board of Directors for elimination from the certification examination blueprint. This was the approach used for the 2012 Task Analysis, as it was determined by Research Committee members that item importance and frequency should be weighted equally. This strategy seemed a reasonable method for exclusion of items based on the pre-determined cutoff value (importance + frequency scores), comments from the respondents, and available demographic factors (e.g., length of time in practice, type of practice). This approach involved examination of the unweighted composite score (mean importance + mean frequency) of all clinical tasks that received a score of 5 or less. Where the unweighted composited score for a given task fell between 3 and 5, close attention was given to the frequency and importance scores for consideration of elimination or retention. Of the 241 total tasks, 44 (18.3%) had an unweighted composite score of less than 5 and thus were considered for inclusion in the list of tasks recommended by the Research Committee for consideration of elimination by the Board of Directors. After final deliberation, the Research Committee recommended 24 tasks (10%) to the AMCB Board of Directors to be considered for elimination (Table 37). After board deliberation, 18 of the initial 241 tasks (7.5%) were selected for elimination by the Board of Directors (Table 38).

Calculation of the Examination Test Specifications Weights

The AMCB certification examination is constructed to align to test specifications based on the results of the task analysis. Each of the 6 practice areas containing clinical task items (Antepartum, Intrapartum, Postpartum, Newborn, Well-Woman/Gynecology, and Primary Care)

is assigned a weight that determines how many items representing that practice area will appear on the examination. The new test specification weights for the six practice areas were computed based on a combination of the mean ratings of importance and frequency for each task assigned by survey respondents as well as from survey respondent-suggested weights (Table 39). Survey respondent-suggested weights were calculated based on the following survey item: "*For each of the six full-scope midwifery practice areas, what percentage of exam items would you assign to each area based on its importance?*". Participants were asked to provide a value for each of the six practice areas so that the total summed to 100%.

To calculate preliminary test specification weights for the examination, an additive model was used which involved combining the mean importance and mean frequency ratings of all clinical task items in each practice area to produce the weights for the six major practice areas. This information was then aggregated with survey respondent-suggested weights. The calculation of weights was thus accomplished in the following steps:

1. For each task, the mean frequency and mean importance ratings were summed.
2. For all tasks within each practice area, the sums of the mean ratings were averaged to produce a mean rating for each practice area.
3. The practice area mean ratings were then summed. This provided a grand total for all six practice areas.
4. Each of the six practice area mean rating totals were divided by the grand total. This provided the proportion of the total examination accounting for each practice area. Multiplying the proportions by 100 provided the percentage of the examination for each of the six practice areas.
5. Survey respondent-suggested ratings for each practice area were then added to the percentage of the examination for the same practice area calculated in step 4 and the result divided by two. Thus, final test specification weight estimates were calculated as the average of the weights derived from the frequency and importance items and the participant-suggested weights. The number of items was produced based on the corresponding percentages.

Participants also were asked what percentage of their current practice deals with patients having abnormal conditions. Table 40 identifies participant opinion regarding the percentage of

practice dealing with normal versus abnormal conditions and provides comparison with the participant estimates from the 2012 Task Analysis.

RESULTS

Table 2 displays data on survey respondents, survey population, and the AMCB population for comparison. Research committee members reviewed demographic data of the respondent group and compared it to the AMCB population and found the respondent data adequately represented the AMCB population. Consistent with the survey and AMCB populations, most of the respondents were CNMs, female, and White. Only six (1.7%) respondents were CMs. The mean age of survey respondents was 35.7 years compared to 47.9 years for the AMCB population (Tables 3 through 5). The highest earned degree was a master's degree (n = 315, 90.5%), Doctor of Nursing Practice (n = 23, 6.6%), or PhD (n = 2, 0.6%) (Tables 6 and 7).

Most CNMs/CMs (n = 286, 82.2%) worked as an RN before certification for a mean of 8.57 (s.d. 6.14) years (Tables 8 and 9). All respondents reported that they were working as midwives; 313 (89.9%) full-time, 23 (6.6%) part-time, or 9 (2.6%) per diem (Tables 10 and 11). Respondents reported that they were primarily practicing in 46 states, in one overseas location, and 14 (4%) of responding CNMs/CMs practiced in more than one state (Tables 12 through 14). The majority practiced in cities with populations over 100,000 (Table 15). Most of the respondents (n = 223, 66.9%) reported that their only certification was as a CNM/CM; while 66 (19.8%) were also certified as Women's Health Care Nurse Practitioners, 21 (6.3%) as Family Nurse Practitioners, and 12 (3.6%) as Certified Lactation Consultants (Tables 16 through 18). 94% of respondents had prescriptive authority (Table 19).

The primary midwifery employer was a hospital (n = 107, 30.7%) followed by a physician group (n = 96, 27.6%). Tables 20 and 21 display the primary midwifery employer of the respondents. 275 (79%) of respondents had hospital privileges, 26 (7.5%) had pending hospital privileges and 45 (12.9%) did not have hospital privileges (Table 22). Hospital staff membership was obtained through medical staff status by 158 (45.4%) and allied health staff status by 55 (15.8%) of CNMs/CMs. However, 58 (16.7%) of the respondents did not know how they

obtained hospital staff membership, and 74 (21.3%) of respondents did not answer this question (Table 23).

Respondents reported spending approximately 40 minutes responding to the survey and that the survey instructions were clear (Tables 24 through 26). Over 80% of respondents reported that the current eligibility requirements for certification and requirements for subsequent recertification were appropriate to achieve and maintain competence as a midwife (Table 27). Those who did not agree that the current eligibility requirements for certification were necessary to achieve midwifery competence cited their disagreement with requiring both verification and attestation by the midwifery program director prior to sitting for the certification exam, the belief that RN licensure and/or nursing experience either were or were not essential to achieving competence as a midwife, the presence of alternative valid methods to become prepared as a midwife, and the suggestion to require specific GYN case experiences prior to sitting for the exam (Tables 28 and 29). Comments regarding recertification requirements focused primarily on the requirement to obtain CEUs in addition to completing certificate maintenance modules with a preference for only requiring CEUs and concerns related to the modules themselves (e.g., obtaining necessary articles and sharing answers to the questions in the modules) (Table 30).

Clinical Tasks

A total of 241 clinical tasks were identified across the six midwifery practice areas: antepartum, intrapartum, postpartum, newborn, well-woman/gynecology, and primary care. A summary of survey responses for frequency and importance of clinical tasks for each practice area may be found in Tables 31 through 36. In addition to the number of responses for each item, the composite score (unweighted) for each item is provided. Unweighted scores of 5 or less (n = 41, 17%) were reviewed by all Research Committee members as potential tasks for recommendation to the Board of Directors for elimination. The decision for recommendation for elimination was not based solely upon the numerical values, but also took into consideration whether the clinical tasks were inherent to the philosophy and practice of midwifery, for example Centering Pregnancy®.

Of the 241 total tasks presented, 23 (9.5%) were recommended by the Research Committee for consideration for elimination from the examination blueprint by the Board of

Directors (Table 37). Identified items occurred across all practice areas though the fewest were recommended for elimination from the antepartum practice area. The items recommended for consideration for elimination by area of practice were two antepartum, five intrapartum, one postpartum, one newborn, eight well-woman/GYN, and six primary care clinical tasks. After deliberation, the Board of Directors approved the elimination of 18 of the 23 proposed items (78.3%) (Table 38). The items selected for elimination by area of practice by the Board of Directors were one antepartum, four intrapartum, one postpartum, one newborn, six well-woman/GYN, and five primary care clinical tasks.

Antepartum

Antepartum tasks included a total of 45 items (Table 31). Most respondents (n = 325, 93.39%) indicated that they provided antepartum care, while 23 (6.61%) indicated that they did not (Table 41). The majority (75.6%) provided antepartum care in an outpatient clinic or office (Table 42). Only those respondents who reported providing antepartum care participated in this portion of the survey. All antepartum tasks scored 4 or higher in **frequency** except: *counsels where spontaneous abortion or intrauterine fetal demise has occurred (3.96); determines appropriateness of vaginal birth after cesarean (VBAC) and counsels for risk/benefit* (3.95); *evaluates bony pelvis* (3.86); *counsels for substance abuse (3.84); interprets biophysical profile* (3.76); *provide counseling for best birth setting (i.e., home, birth center, hospital)* (3.26). *evaluates for and manages woman with A2 diabetes in pregnancy (pharmaceuticals, diet, exercise, glucose monitoring, fetal surveillance)* (3.10); *performs sonography for amniotic fluid volume, presentation, and/or placental location* (2.29); *performs sonography independently to establish or confirm gestational age* (1.97); *provide group or Centering Pregnancy® care* (1.56); *performs biophysical profile* (1.27); and *performs sonogram to rule out fetal abnormality* (1.17). The highest scoring items for **frequency** included *orders/obtains/interprets laboratory tests to determine baseline values and deviations from normal* (4.98); *questions woman about fetal movement and instructs her in fetal movement monitoring* (4.96); *counsels woman and family about normal physiology of pregnancy, common discomforts, and self-care during pregnancy* (4.96); *orders/obtains/interprets laboratory work during the pregnancy* (4.96); *performs Leopold's maneuvers on abdomen to determine presentation, lie, position of fetus, and estimated weight of fetus* (4.95); *identifies deviations from normal pregnancy; develops a management*

plan to respond to deviations; consults and/or refers as necessary (4.94); *measures abdomen by centimeter tape and/or fingerbreadth to assess fundal height and fetal growth* (4.94); and *prepares the woman and her family for pain management in labor and discusses options* (4.9).

None of the antepartum items scored greater than or equal to 4 or less than 2 for **importance**. The highest scoring items for importance were: *identifies deviations from normal pregnancy and develops management plan* (3.97); *orders, obtains and interprets laboratory values and deviations from normal* (3.96); *orders/obtains/interprets laboratory work during the pregnancy* (3.92); and *interprets labs for pregnancy-induced hypertension* (3.91). Only six items scored < 3 for importance: *performs sonography for amniotic fluid volume, presentation, and/or placental location* (2.63); *provides group or Centering Pregnancy® care* (2.6); *evaluates bony pelvis and determines pelvic type* (2.46); *performs sonography independently to establish confirm gestational age* (2.36); *performs biophysical profile* (2.18); and *performs sonogram to rule out fetal abnormality* (2.00).

Tasks with **unweighted composite scores** of less than 5 included: *performs sonography for amniotic fluid volume, presentation, and/or placental location* (4.92); *performs sonography independently to establish or confirm gestational age* (4.33); *provide group or Centering Pregnancy (TM) care* (4.16); *performs biophysical profile* (3.44); and *performs sonogram to rule out fetal abnormality* (3.17).

Intrapartum

Intrapartum tasks included a total of 60 items (Table 32). Most respondents (n = 310, 89.08%) indicated that they provided intrapartum care, while 33 (9.48%) indicated that they did not (Table 43). The majority of respondents provided intrapartum care in hospital (n = 284, 81.6%) while 42 (12.1%) provided care in an out-of-hospital birth center (Table 44). The following tasks were found to have the highest calculated mean **frequency** score (greater than or equal to 4): *determines fetal position* (4.96); *provides emotional support to the woman and her family* (4.93); *develops a plan for decreasing comfort in labor* (4.92); *inspects placenta and membranes to ascertain their completeness, to rule out retained fragments, and to check for abnormalities* (4.91); *monitors progress of labor by vaginal determination of cervical position, effacement, and dilation, descent of presenting part, and position of presenting part* (4.91);

evaluates physical response to process of labor (4.91); *evaluates woman for onset of labor* (4.90); *estimates blood loss* (4.89); *determines position of presenting part by abdominal and vaginal exam* (4.89); *examines cervix, vagina, and perineum for lacerations and/or episiotomy extensions and identifies need for repair* (4.89); *evaluates fetal condition following rupture of membranes to determine fetal well-being* (4.88); *promotes effective second stage of labor progress* (4.88); *delivers placenta and membranes by means of maternal effort and/or gentle manual traction* (4.86); *delays cord clamping until pulsations have ceased unless earlier severance is medically indicated* (4.84); *initiates plan of care for managing deviations from the normal progress of labor* (4.83); *determines separation of placenta* (4.81); *monitors the labor pattern through palpation to observe the strength duration, and frequency of contractions* (4.78); *determines status of amniotic membranes by woman's report, observation for pooling of fluid, use of nitrazine paper, and/or exam of fluid for ferning* (4.76); *initiates a plan to meet the nutritional needs of the laboring woman* (4.73); *repairs episiotomy and/or 1st or 2nd degree lacerations of the perineum* (4.73); *delivers infant with mother is various positions, such as side-lying, knee-chest, or squatting* (4.69); *monitors fetal well-being and response to contractions through the application of external electronic fetal monitor tracing* (4.63); *manages nuchal cord* (4.62); mana*ges or co-manages care of the woman with an epidural* (4.59); *initiates active management of the third stage of labor* (4.54); *performs artificial rupture of membranes* (4.51); *estimates gestational age and fetal weight incorporating all available data* (4.47); *administers local anesthesia* (4.44), *orders/administers cervical ripening agents* (4.41); cont*rols hemorrhage by pharmaceutical administration, fundal massage, bimanual compression, initiation of breastfeeding and/or vaginal/cervical laceration repair* (4.37); *evaluates for chorioamnionitis* (4.27); *orders pitocin for augmentation of labor* (4.18); *and evaluates etiology of postpartum hemorrhage, including uterine atony and vaginal/cervical lacerations* (4.14).

Tasks with a calculated low mean frequency score (less than or equal to 2) included: *repairs 3rd degree laceration* (1.30); *delivers baby in face presentation* (1.27); *administers pudendal anesthesia* (1.20); *delivers baby in breech position* (1.10), *repairs lacerations of the cervix* (1.08); *delivers baby with vacuum* (1.05); *delivers baby with forceps* (1.01); *and repairs 4th degree lacerations* (1.00).

Importance scores ranged from a low of 1.75 (*delivers baby with forceps*) to a high of 3.97 (*initiates maneuvers to resolve shoulder dystocia* and *controls hemorrhage by pharmaceutical administration, fundal massage, bimanual compression, initiation of breastfeeding and/or vaginal/cervical laceration repair*). Items with a low mean score (≤ 2) were: deliver*s baby with forceps* (1.75); *repairs 4th degree lacerations* (1.87); and *administers pudendal anesthesia* (1.99). The highest importance tasks (3.75 or greater) were: *delivers infant in the occiput posterior position (OP)* (3.75); *manages or co-manages care of the woman with an epidural* (3.76); *monitors fetal well-being and response to contractions through the application of external electronic fetal monitor tracing* (3.76); *monitors labor pattern through palpation to observe the strength, duration, and frequency of contractions* (3.76); *delays cord clamping until pulsations have ceased unless earlier severance is medically indicated* (3.80); *estimates blood loss* (3.84); *evaluates for chorioamnionitis* (3.84); *delivers placenta and membranes by means of maternal effort and/or gentle manual traction* (3.86); *determines separation of placenta* (3.87); *delivers infant with mother in various positions, such as side-lying, knee-chest, or squatting* (3.88); *develops a plan for decreasing discomfort in labor* (3.88); *performs bimanual compression* (3.88); *evaluates physical response to process of labor* (3.89); *promotes effective second stage of labor progress* (3.89); *evaluates woman for onset of labor* (3.91); *initiates a plan for managing deviations from the normal progress of labor* (3.92); *determines position of presenting part by abdominal and vaginal exam* (3.92); *monitors progress of labor by vaginal determination of cervical position, effacement and dilation, descent of presenting part, and position of presenting part* (3.92); *manages nuchal cord* (3.93); *inspects placenta and membranes to ascertain their completeness to rule out retained fragments, and to check for abnormalities* (3.93); *evaluates fetal condition following rupture of membranes to determine fetal well-being* (3.93); *examines cervix, vagina, and perineum for lacerations and/or episiotomy extensions and identifies need for repair* (3.94); *provides emotional support to the woman and her family* (3.94); *determines status of amniotic membranes by woman's report, observation for pooling of fluid, use of nitrazine paper, and/or exam of fluid for ferning* (3.94); *repairs episiotomy and/or 1st or 2nd degree laceration* (3.95); *evaluates etiology of postpartum hemorrhage, including uterine atony and vaginal/cervical lacerations* (3.95); *determines fetal presentation* (3.96); *initiates maneuvers to resolve shoulder dystocia* (3.97); and *controls*

hemorrhage, by pharmaceutical administration, fundal massage, bimanual compression, initiation of breastfeeding and/or vaginal/cervical laceration repair (3.97).

Unweighted composite scores for intrapartum tasks that fell below a cut-point score of 5 were: *delivers baby with forceps* (2.76), *repairs 4th degree lacerations* (2.87), *delivers baby with vacuum* (3.07), *repairs lacerations of the cervix* (3.08), *administers pudendal anesthesia* (3.19), *repairs 3rd degree lacerations* (3.48), *delivers baby in breech presentation* (3.52), *delivers baby in face position* (3.81).

Postpartum

Postpartum tasks included a total of 15 items (Table 33). Most respondents (n = 285, 81.9%) indicated that they provided postpartum care, while 22 (6.32%) indicated that they did not (Table 45). *Performs postpartum physical exam received* the highest mean **frequency** score (4.87) with other high-frequency items including: *discusses with woman/family plans for continued health care for mother and well-baby care for infant* (4.85); *provides information about breast anatomy and physiology, maintenance of milk supply, and care of lactation problems (e.g., sore nipples, engorgement, mastitis)* (4.74); *screens the woman during the postpartum period for symptoms of depression with a standardized psychological instrument* (4.69); *screening for anxiety* (4.68); *evaluates for postpartum abnormalities (e.g., anemia, DVE, UTI, endometritis)* (4.65); *provides lactation support* (4.62); *manages postpartum/procedural pain* (4.57); *refers for lactation consultation as indicated* (4.54); *assesses and manages postpartum hemorrhoids, including pharmaceuticals* (4.44); and *orders maternal immunization in immediate postpartum* (4.20). One item received a low mean frequency score of less than or equal to 2: *lanced external thrombosed hemorrhoids* (1.28).

There were no postpartum scores for **importance** that were 4 or greater. *Screening the woman during the postpartum period for depression with a standardized psychological instrument* received the highest mean score for importance (3.95). This was closely followed by: *performs postpartum physical exam* (3.92); and *evaluates for postpartum abnormalities (e.g., anemia, DVE, UTI, endometritis)* (3.90). Other postpartum tasks receiving high mean importance scores included: *providing information about breast anatomy and physiology, maintenance of milk supply, and care of lactation problems (e.g., sore nipples, engorgement, mastitis)* (3.87);

screens for anxiety (3.86); *provides lactation support* (3.85); *refers for lactation consultant as indicated* (3.83); and *discusses with woman/family plans for continued health care for mother and well-baby care for infant* (3.83). *Lanced external thrombosed hemorrhoids* received the lowest mean importance score (2.07).

The lowest average item score for both frequency and importance is *lance external thrombosed hemorrhoids*. The low **unweighted composite score** for *lancing thrombosed hemorrhoids* (3.34) met criteria for consideration for elimination from postpartum tasks, and was the only postpartum item with a weighted composite score of less than 5.

Newborn

Newborn tasks consisted of 30 items (Table 34). Most respondents (n = 237, 68.10%) indicated that they did not provide newborn care, while 65 (18.68%) indicated that they did (Table 46). The task **frequency** mean scores ranged from a low of 1.23 (*performs intubates infant with laryngoscope*) to a high of 4.83 (*creates environment for healthy maternal-infant interaction*). Other low-scoring frequency items for newborn tasks (≤ 2) included: *performs male infant circumcision* (1.31); *manages infants requiring phototherapy* (1.46); and *orders immunizations during the neonatal period* (1.86). Other high mean frequency score items (≥ 4) included: *provides education about newborn feeding* (4.77); *examines cord for umbilical vessels* (4.75); *supports newborn thermoregulation* (4.74); *educates about breastfeeding and assist with technique* (4.69); *maintains infant's temperature* (4.65); *observes and clears infant's breathing passages* (4.53); *promotes adequate respirations by stimulating the newborn* (4.45); *provides guidance concerning newborn care* (4.42); *evaluates infant for transition to extrauterine life* (4.40); *evaluates well-being of the newborn by means of APGAR scoring* (4.22); *orders and administer Vitamin K* (4.22); *provides guidance and counselling regarding male circumcision* (4.20); *collects cord blood* (4.11); and *performs complete newborn physical exam* (4.05).

The lowest mean task **importance** score was *performs male infant circumcision* (1.9). Newborn tasks with highest mean importance scores were: *promotes adequate respirations by stimulating the newborn* (3.98); *supports newborn thermoregulation* (3.98); *maintains infant temperature* (3.97); *educates about breastfeeding* (3.94); *resuscitates infant by use of positive pressure breathing bag* (3.92); *observes and clears infant's breathing passages* (3.91); *creates*

an environment for healthy maternal-infant interaction (3.88); *provides education about newborn feeding* (3.86); *provides guidance concerning newborn care* (3.81); and eva*luates infant for transition to extrauterine life* (3.80).

There were 5 items that had **unweighted composite scores** of less than 5, and thus met criteria for consideration for elimination from newborn tasks. These items included: *performs male infant circumcision* (3.21); *manages infants who require phototherapy* (3.71); *performs infant intubation with laryngoscope* (3.97); *orders immunizations during the neonatal period* (4.35); and *manages well-baby visits past 1week of age* (4.84).

Well Woman/Gynecology

Well-woman/gynecology tasks included a total of 58 items (Table 35). Most respondents (n = 267, 76.72%) indicated that they provided well-woman/gynecology care, while 34 (9.77%) indicated that they did not (Table 47). The highest calculated mean **frequency** scores (greater than or equal to 4) were reported for: *provides detailed information on contraceptive options* (4.92); *screens for indications and contraindications for various contraceptive methods by history and physical examination and laboratory data* (4.87); *gathers information about the woman's personal gynecological history and present health status* (4.83); *assesses woman for sexually transmitted infections (e.g., gonorrhea, syphilis, Chlamydia, HPV, HSV, HIV)* (4.82); *obtains Papanicolaou test* (4.81); *counsels women about prevention an recognition of sexually transmitted infections* (4.78); *provides instruction and counseling regarding use of condoms as a method of contraception or STD prevention* (4.74); *instructs, orders, and manages women using oral contraceptives* (4.72); *prescribes pharmaceuticals and/or alternative therapies for treatment of vaginitis* (4.71); *assesses the woman for high-risk sexual behavior* (4.62); *evaluates for sexual orientation* (4.59); *evaluates woman for menstrual irregularities* (4.55); *evaluates for sexual dysfunction* (4.46); *performs a wet mount or culture for diagnosis of vaginitis* (4.38); *counsels woman regarding normal physiological and emotional changes throughout the menstrual cycle* (4.34); *orders standard screening tests for women (e.g., thyroid function, Tb skin test, mammography, DEXA scan, colonoscopy)* (4.29); *prescribes oral, injectable and emergency contraceptives* (4.24); *treats woman for sexually transmitted infections (e.g., gonorrhea, syphilis, Chlamydia, HPV, HSV)* (4.24); *inserts intrauterine devices (i.e., paragard, Mirena IUS)* (4.22);

arranges for colposcopy when physical and/or cytologic findings indicate doing so (4.21); and *provides guidance, instruction, and counseling regarding natural family planning methods (e.g., Billings, rhythm, symptothermal and lactational amenorrhea)* (4.04).

Low-frequency tasks scoring less than or equal to 2 included: *provides counseling and support of woman following a sexual assault* (1.96); *performs endometrial biopsy* (1.87); *prescribes pharmaceuticals for treatment of infertility* (1.83); *orders sonohystogram* (1.81); *provides diaphragm fitting and instruction* (1.68); *performs pre-hysterectomy and post-hysterectomy counseling* (1.60); *treats condyloma using cryotherapy* (1.56); *counsels and refers woman for the cervical cap method of contraception* (1.53); *performs vulvar biopsy* (1.49); *medically manages ectopic pregnancy (i.e., methotrexate)* (1.49); *provides paracervical block for IUD insertion* (1.41); *provides cervical cap fitting and instruction* (1.31); *evaluates for and performs Essure and/or Adiana permanent sterilization* (1.29); *performs endocervical curettage* (1.29); *performs gynecological sonogram* (1.26); *performs colposcopy* (1.24); *performs sexual assault examination* (1.24); *performs artificial insemination* (1.13); and *first assists at GYN surgery* (1.12).

Importance scores ranged from a low of 1.86 (*first assists at GYN surgery*) to a high of 3.94 (*gathers information about the woman's personal gynecological history and present health status*). The only item of importance less than or equal to 2 included: *first assists at GYN surgery* (1.86).

The highest importance tasks (greater than or equal to 3.75) were: *gathers information about the woman's personal gynecological history and present health status* (3.94); *treats woman for sexually transmitted infections* (3.92); *assesses woman for sexually transmitted infections* (3.91); *screens for indications and contraindications for various contraceptive methods by history and physical examination and laboratory data* (3.91); *provides detailed information on contraceptive options* (3.91); *instructs, orders and manages women using oral contraceptives* (3.91); *counsels woman about prevention and recognition of sexually transmitted infections* (3.90); *obtains Papanicolaou test (3.90); prescribes pharmaceuticals and/or alternative therapies for treatment of vaginitis* (3.86); *provides instruction and counseling regarding use of condoms as a method of contraception or STD prevention* (3.85); *prescribes*

oral, injectable and emergency contraceptives (3.85); *arranges for colposcopy when physical and/or cytological findings indicate doing so* (3.85); *assesses the woman for high-risk sexual behavior* (3.84); *inserts intrauterine devices (i.e., paragard, Merina IUS)* (3.81); *performs a wet mount or culture for diagnosis of vaginitis* (3.78); and *evaluates woman for menstrual irregularities* (3.78).

Unweighted composite scores for well-woman/gynecology tasks resulted in the following 16 tasks that fell at/near or below a cut-point score of 5: *removes condyloma using chemical methods* (4.97); *performs endometrial biopsy* (4.65); *prescribes pharmaceuticals for treatment of infertility* (4.59); *orders sonohystogram* (4.48); *provides diaphragm fitting and instruction* (4.30); *medically manages ectopic pregnancy (i.e., methotrexate)* (4.25); *treats condyloma using cryotherapy* (4.12); *performs vulvar biopsy* (4.09); *performs pre-hysterectomy and post-hysterectomy counseling* (4.05); *performs sexual assault examination* (3.96); *counsels and refers woman for the cervical cap method of contraception* (3.92); *provides cervical cap fitting and instruction* (3.63); *provides paracervical block for IUD insertion* (3.63); *performs colposcopy* (3.61); *performs endocervical curettage* (3.50); *performs gynecological sonogram* (3.38); *evaluates for and performs Essure and/or Adiana permanent sterilization* (3.34); *performs artificial insemination* (3.25); and *first assists at GYN surgery* (2.98).

Primary Care

Primary care tasks included 31 items (Table 36). Most respondents (n = 183, 52.59%) indicated that they did not provided primary care, while 111 (31.9%) indicated that they did (Table 48). The highest calculated mean **frequency** scores (greater than or equal to 4) were reported for: *interviews woman about her family history, personal medical, surgical, obstetrical, gynecological, sexual, and social history, and pregnancy* (4.90); *assesses mental and emotional status through the use of history-taking and interviewing techniques* (4.85); *questions and counsels woman regarding use of medications, recreational drugs, smoking, alcohol, and caffeine* (4.83); *examine and evaluates for vaginal, cervical, uterine and adnexal abnormalities (e.g., bimanual exam, diagnostic imaging, laboratory testing)* (4.80); *evaluates breasts for abnormalities (e.g., masses, fissures)* (4.71); *assesses for signs of genitourinary infection, including physical assessment, laboratory findings, and manages as indicated* (4.71); *educates*

the woman about safe sexual practices (4.65); *assesses woman for mood disorders (e.g., anxiety, depression, bipolar disorder, eating disorders)* (4.62); *assesses the woman for high risk sexual behavior* (4.59); *assesses and refers woman for risk of domestic violence or sexual abuse* (4.54); *orders standard screening tests for women (e.g., thyroid function, Tb skin test, mammography, DEXA scan, colonoscopy* (4.46); *inspects skin for abnormalities (e.g., discoloration, lesions) and treats as indicated* (4.41); *evaluates for cardiac abnormalities (e.g., murmur, irregularity) and refers as indicated* (4.39); *orders immunizations based on history, age, and recommendation of appropriate specialty groups* (4.16); and *assesses and counsels woman regarding sexual satisfaction or dysfunction* (4.04).

There were five low frequency tasks scoring less than or equal to 2: *performs removal of abnormal lesions* (1.77); *sutures minor wounds* (1.73); *performs skin biopsy* (1.37); *performs cortisone injections* (1.16); and *performs breast biopsy* (1.10).

Importance scores ranged from a low of 1.85 (*performs cortisone injections*) to a high of 3.95 (*interviews woman about her family history, personal medical, surgical, obstetrical, gynecological, sexual and social history, and pregnancy*). Tasks of highest importance (equal to or greater than 3.75) included: *interviews woman about her family history, personal medical, surgical, obstetrical, gynecological, sexual and social history, and pregnancy* (3.95); *examine and evaluates for vaginal, cervical, uterine and adnexal abnormalities (e.g., bimanual exam, diagnostic imaging, laboratory testing)* (3.93); *assesses and refers woman for risk of domestic violence or sexual abuse* (3.93); *evaluates breasts for abnormalities (e.g., masses, fissures)* (3.92); *assesses mental and emotional status through the use of history-taking and interviewing techniques* (3.91); *assesses for signs of genitourinary infection, including physical assessment, laboratory findings, and manages as indicated* (3.91); *educates the woman about safe sexual practices* (3.89); *questions and counsels woman regarding use of medications, recreational drugs, smoking, alcohol, and caffeine* (3.88); *orders standard screening tests for women (e.g., thyroid function, Tb skin test, mammography, DEXA scan, colonoscopy)* (3.84); *assesses the woman for high risk sexual behavior* (3.83); *assesses woman for mood disorders (e.g., anxiety, depression, bipolar disorder, eating disorders)* (3.83); and *assesses the woman for high risk sexual behavior* (3.82).

Primary care items of lowest importance (less than or equal to 2) included: *performs breast biopsy* (1.99); and *performs cortisone injections* (1.85).

Unweighted composite scores for primary care tasks resulted in the following six tasks that fell at/near or below a cut-point score of 5: *performs cortisone injections* (3.01); *performs breast biopsy* (3.09); *performs skin biopsy* (3.57); *sutures minor wounds* (3.98); *performs removal of abnormal lesions (e.g., skin tags, nevus) as indicated (e.g., cautery, scalpel, liquid nitrogen)* (4.15); and *evaluates and treats minor wounds* (4.86).

Test Specifications Weights

The calculated test specification weights are shown in Table 39. These weights are based on mean scores of the frequency and importance ratings aggregated with survey participant-assigned weights (the weights are based on the tasks that were retained by AMCB). Intrapartum has the largest test specification weight at 21.6%, followed closely by antepartum which has a test specification weight of 20.8%. Postpartum and well-woman/GYN test specification weights were comparable as they are 16.8% and 16%, respectively. Primary care and newborn weights were the lowest and were 12.8% and 12%, respectively. Comparison of the new calculated test weights with the current test specifications (i.e., derived from the 2012 Task Analysis) show relatively small changes among the 6 major categories, having at most a difference of approximately 1%.

Participants were also queried as to the percentage of their overall practice that dealt with patients with abnormal conditions (Table 40). Respondents in this survey reported 48.35% of their practice dealt with patients who had abnormal conditions; whereas, respondents to the 2012 Task Analysis survey indicated 41% of their practice dealt with patients who had abnormal conditions. This reflects a 7.35% increase from the last task analysis.

Free-Form Responses

Respondents were permitted to provide comments about the tasks provided in each area of clinical midwifery practice. Appendix L lists the unedited participant comments by area of midwifery practice. Respondents commented on practice variations based on clinical setting, restrictions on midwifery practice, confusion over item wording, and the need for clearer

definitions (e.g., gestational hypertension should replace PIH, unsure about the use of "counseling"). Several respondents made suggestions of tasks to include on future task analyses. These suggestions largely related to risk identification and issues of women declining to accept care (i.e., flu shot, GBS screening, and RhoGam). There were some topics suggested for inclusion in future surveys that were included in one area of midwifery practice but not in others. For example, pre-eclampsia-related tasks were identified as antenatal tasks, but were not listed under intrapartum or postpartum practice areas. Placing a given task in a primary area of practice was done in an effort to keep the survey length manageable, thus minimizing subject burden. This decision should be reconsidered with additional task analysis surveys.

Antepartum

There was a total of 24 respondent comments related to antepartum tasks. Several comments reflected the interdisciplinary nature of nurse-midwifery practice and noted that some tasks were managed collaboratively instead of solely by the midwife. In addition, respondents noted that untrasonographic procedures were not included in their midwifery education and were frequently referred to another provider such as a physician or ultrasonographer. There were also comments regarding the importance of new midwives understanding normalcy and being able to identify deviations from normal as opposed to managing women with abnormal conditions. Respondents suggested adding tasks related to antepartum and postpartum depression screening, counseling about weight gain in pregnancy, and shared decision making regarding intervention.

Intrapartum

There was a total of 20 free form responses for the intrapartum tasks. Tasks that respondents suggested should be added to the survey were: *accompanies woman during intrapartum transport to provide continuity of care*, *measures blood loss*, *management of labor dystocia*, *administers and manages narcotics during labor*, *sonography in labor*, *nitrous oxide administration during labor*, and *foley/Cook balloon insertion for cervical ripening*. The remainder of comments were contextual comments regarding the nature of the practice setting, or setting-dependent policies that limit the CNM/CM from performing a task.

Postpartum

There were 15 comments for the postpartum tasks. Participants indicated that they felt that some important postpartum tasks were excluded from the survey including but not limited to: discussion of birth control/contraceptive options in early as well as late postpartum, provision of postpartum pain management, referral for postpartum complications (physical and psychological), initiating care for postpartum depression, management of perinatal mood disorders, assessing support system, co-management of post cesarean section patients, and the fact that some midwives are also lactation consultants.

Newborn

The 5 comments on newborn tasks centered around who is responsible for providing newborn care in the practice facility. According to the comments, newborn care may be performed by nurses, pediatricians, midwives, or "pediatric specific providers."

Well-Woman/Gynecology

For well-woman/GYN tasks, there were 20 comments. Respondents identified tasks that they felt were missing from the survey which included pessary use, management of obesity, counseling for pregnancy options, care of men transitioning to female (trans men), care of LGBTQ patients, genetic counseling and testing (e.g., BRCA 1, 2), annual screenings, urinary tract infections, and substance use/abuse. Respondents offered comments which described practice restrictions on writing prescriptions to treat partners for STIs, and other restrictive protocols that place limits on the CNM/CM scope of practice.

Primary Care

Comments focused on primary care practice (five statements) suggested the need for items related to diabetes screening and management and mood disorders.

Participant Suggestions for Tasks on Future Task Analyses

Respondents were asked what items they would like to be added to future task analyses. Appendix M lists the unedited participant suggestions for task to be included in future task analyses. The suggestions are as follows: family planning, cultural safety, fertility and infertility for biological female patients and transgender patients, lactation, leadership, quality

improvement, quality assurance, peer review, elective termination of pregnancy, birth setting specific information, patient care for a variety of populations, ultrasounds, mental health care, cesarean sections, complementary and alternative therapies such as homeopathy and essential oils, childbirth education, postpartum care and support, care of trans men, partner STD diagnosis and treatment, and primary care for the menopausal population.

DISCUSSION

Review of clinical task ratings demonstrated that 44 out of a total of 241 items (18.3%) should be considered for elimination from the certification examination blueprint based solely upon receiving an unweighted composite score of 5 or less (Tables 31 through 36). Generally, the scores on these items demonstrate the tasks to be, in combination, of both low importance and frequency. Those 44 tasks with an unweighted composite score of less than or equal to 5 occurred across the 6 midwifery clinical practice areas where five antepartum, eight intrapartum, one postpartum, five newborn, 19 well-woman/GYN, and six primary care tasks were identified. Members of the Research Committee reviewed each of the 44 items receiving an unweighted composite score of 5 or less and decided to recommend that the Board of Directors consider the elimination of 23 items (52.3%) from the test blueprint (Table 37). Research Committee decisions about retention or elimination of individual tasks were reached through consensus. The AMCB Board of Directors then considered these 23 tasks recommended for elimination and made the final decision to eliminate 18 (78.3%) of them across the 6 domains (one antepartum, four intrapartum, one postpartum, one newborn, six well-woman/GYN, and five primary care tasks) (Table 38).

Limitations

This task analysis had several important limitations. First, the overall response rate was 25.4%, which was lower than the 2012 Task Analysis survey which had a response rate of 34%, thus raising questions about response bias and generalizability. While the response rate is comparable to other surveys of a similar nature and may be considered adequate for a practice analysis survey, it falls below the current expectations for survey response rates to approximate 60-80% as is typical for online surveys (Fincham, 2008; Scott, 2011). If an e-mail survey is utilized in future task analyses, an effort should be made to increase the response rate, ideally by

using multimodal strategies (e.g., e-mail and/or mailed options, telephone recruitment, or telephone survey) as these have been demonstrated to enhance response rates (Nicholls et al., 2011). Consideration of compensation approaches may also be helpful. In the 2012 Task Analysis, each individual participant was compensated with a one-year certificate maintenance fee waiver ($65.00), and in this task analysis a lottery drawing for 10 mini iPADs was used along with an individual award of 10 contact hours counting toward certification maintenance requirements. It is unknown how this change in compensation might have impacted response rates.

Response rates may have been impacted by sending an e-mail invitation for accessing the URL for survey participation. Some emails were likely screened by spam filters and it is unknown how many emails were screened out by these filters as well as how many emails were actually opened and read. All things considered and given AMCB project resources, e-mail was chosen because it was less costly and was the most efficient and timely manner for contacting survey participants. Should future practice analysis surveys again use e-mail invitations, it will be important to consider distribution strategies to increase the number of deliverable e-mails and to verify that the e-mails were read.

Failure to follow-up on non-respondents, a potential source of study error and important for accurately interpreting survey findings (Davern, 2013), was a second limitation of this research. Future practice analysis surveys should consider follow-up surveys of non-respondents to determine reasons for non-response and to identify differences between those who did and did not respond. While unknown, it is likely that survey burden, time limitations, lack of interest, and limited understanding of the importance of the task analysis were factors in non-response to this study.

Another limitation was the length of the survey, which required approximately one hour of respondent time to fully complete. It may have been useful to include a progress bar for each section as feedback to participants. The goal of including a progress bar is to promote completion rates as respondents move from screen to screen, providing reassurance that progress is being made toward finishing the survey (Conrad, Couper, Tourangeau, & Peytchev, 2010). A

completion bar was not an available feature in REDCap, therefore platforms other than REDCap may be considered for future surveys.

An additional limitation was the placement of tasks in the survey only according to dominant related practice area. To reduce survey length, tasks were placed in one dominant practice area even though the task may be performed in multiple practice areas. For example, activities related to family planning care were included in the well-woman/GYN practice area, though these tasks would also be relevant to the postpartum and primary care practice areas. If respondents did not self-identify as providing midwifery care for well women or were not in full scope practice, they would not have had the opportunity to complete the entire survey and family planning tasks would not have been available for rating by the respondent. Several survey participants noted these omissions, so reconsideration of the placement of tasks in only one dominant practice area is important for future practice surveys.

A final limitation of this practice analysis study was the use of a retrospective questionnaire. While retrospective cohort studies are less costly and shorter than prospective cohort design studies, they are susceptible to recall bias and may be incomplete, inaccurate, or inconsistently measured between respondents (Song & Chung, 2010). It would be useful in future practice analyses to consider implementing a prospective design to gain accurate, real-time data. This design could use electronic recording of daily activities; examination of ICD-10-CM, ICD-10-PCS, HCPCS and Level I HCPCS:CPT codes; time-motion study methods; or telephone survey. Use of prospective, real-time data would likely provide more accurate evidence of midwifery services, which may be more influential in shaping subsequent health policy reform (Sonenberg, 2010).

Demographics

The average age of survey respondents was 35.7 years, a finding consistent with the last task analysis and with the average age of students responding to the 2012 ACNM Core Data Survey of ACNM member SNM/SMs, the most recently published data describing SNM/SM and CNM/CM demographics (Fullerton et al, 2015). The average age of ACNM CNMs/CMs in the 2012 ACNM Core Data Survey was 51.4 years while the mean age of the AMCB population is 47.9 years. This decrease in mean age is significant given the projected shortage of maternity

care providers and the projected high numbers of midwives who will be retiring in the near future (Rayburn, 2017; Schuiling, Sipe, & Fullerton, 2010).

Of the survey respondents, only one self-identified as male (0.3%) while 99.1% self-identified as female. This is consistent with the 2012 ACNM Core Data Survey in which 1% of responding ACNM CNMs/CMs and 0.5% of responding ACNM SNMs/SMs self-identified as male (Fullerton et al., 2015). The majority (82.2%) of Task Analysis survey respondents self-identified as White, slightly more than in the current AMCB population (71.5%); and a favorable finding when compared with the 2012 AMCB Core Data Survey where 91.6% of CNMs/CMs and 90.2% of SNMs/SMs self-identified as White. The number of respondents self-identifying as Black or African American (5.2%) dropped from the 2012 Task Analysis Black or African American reported ethnicity rate of 8.2%. All races were represented in this task analysis except for *Native Hawaiian or Other Pacific Islander*, a finding consistent with the 2012 Task Analysis. Given the wide ethnic and racial diversity of women in the US, it is essential that efforts continue to recruit healthcare providers who reflect an increasingly heterogeneous population. The ACNM 2015-2020 Strategic Plan reflects this goal by recognizing Diversity and Inclusion as one of the five core commitments emphasized across all of the College's strategic domains (American College of Nurse Midwives, *n.d.*a). Clear goals relating to diversity and inclusion in the College are also clearly stated in a commissioned expert report titled *Shifting the Frame: A report on diversity and inclusion in the American College of Nurse-Midwives* (American College of Nurse-Midwives, 2015a), which specified three goals:

> "1) Improve the capacity of ACNM members to work effectively across cultures;
> 2) Enhance the success of the profession of midwifery and enrich the American College of Nurse-Midwives by increasing the number of midwives from underrepresented groups in all roles, and at all levels, including leadership; and
> 3) Develop structures and strategies that will equip ACNM leaders to promote diversity, be accountable, support ongoing learning and improvement and cultivate sustained culture of inclusion."

Movement toward these goals will diversify the profession and result in a more ethnically and culturally diverse group of midwifery providers. Continuing to focus on issues of diversity

and inclusion in membership and other professional surveys will allow for the ability to track our progress over time.

Consistent with prior task analysis and membership surveys, few survey respondents were CMs (1.72%) compared to the majority of CNM respondents (97.99%). While only 1.72% of respondents were CMs, this comprised 20.6% (n=29) of CMs who were eligible to participate CNM/CM data were aggregated to maintain anonymity as only six of the eligible 29 CMs completed the Task Analysis survey. 67% of respondents held only CNM/CM certification, while 9.8% also held a Women's Health Care Nurse Practitioner (WHCNP) certification. Of Task Analysis respondents, 82.2% had worked as a nurse for a mean of 8.6 years prior to obtaining midwifery education. An increased number of respondents reported holding a Doctorate of Nursing Practice (DNP) (6.6%) compared to 2012 Task Analysis respondents (< 1%). This is not surprising given that ACNM supports the practice doctorate, although not as a requirement for entry to practice (American College of Nurse-Midwives, 2015b; American College of Nurse-Midwives, 2016). Perhaps what is more surprising is that only 6.6% of respondents reported holding a DNP, given that 19 of the 40 Accreditation Commission for Midwifery Education (ACME)-credentialed programs offer a practice doctorate (American College of Nurse-Midwives, *n.d.*b), and that the majority of nurse-midwifery education programs are housed in schools of nursing accredited by the American Association of Colleges of Nursing who has long endorsed the DNP as necessary education for entry into advanced nursing practice (American Association of Colleges of Nursing, 2004). Further investigation into the reasons midwives do or do not choose to obtain a practice doctorate would be valuable.

A larger percentage of respondents in the current task analysis reported working full-time as a midwife compared to the 2012 Task Analysis (approximately 90% vs. 70%). While it is not possible to ascertain whether this was by choice, it is reassuring that more midwives are working in full-time midwifery practice. The majority of respondents reported working in a hospital/medical center (30.7%) or physician group (27.6%) as opposed to a nurse-midwifery group (12.4%) or community health center (9.8%). This is consistent with the 2012 Task Analysis; however, that task analysis noted a 7% increase in newly certified midwives working in nurse-midwifery groups from the 2007 task analysis while there was no such increase noted

between the 2012 Task analysis and the current study. The reasons for this finding remain unknown and are worthy of further investigation.

New data collected in the 2017 Task Analysis included identifying the setting where respondent midwives attended births. It was noted in the 2012 Task Analysis that the lack of data about birth setting confounded understanding of the conduct of clinical tasks. In this analysis, 81.6% of respondents reported providing intrapartum care in a hospital setting while 12.1% attended births in out-of-hospital birth centers and 4.6% attended births at home. This distribution of birthplace attendance by CNMs/CMs is consistent with 2012 ACNM Member data, where 87.7% of midwives who attended births did so in the hospital, 8.5% in freestanding birth centers, and 7.4% at home (Fullerton et al., 2015). CDC data notes an increasing trend towards out-of-hospital births since 2004 (National Center for Health Statistics, 2014). It will be important to continue to collect this data to observe if a trend toward increased CNM/CM birth attendance in out-of-hospital birth settings emerges in the future.

The 2012 Task Analysis identified a concerning finding that the percentage of respondents working in rural settings had fallen from 7.5% to 5.6% between 2007 and 2012. In this task analysis, the percentage of respondents in rural practice increased to 7.2%. The percentage of newly certified midwife respondents working in urban areas (population >250,000) fell from 60% in the 2012 Task Analysis to 35.3% in the current study. This is a significant finding considering the maldistribution of obstetrician/gynecologists who favor urban areas over rural practice (Rayburn, 2017). It is imperative that CNMs/CMs provide care to women in underserved and rural areas as this is one example of a great health disparity among U.S. women (American College of Obstetricians and Gynecologists, 2016a).

In the current task analysis, 86.5% of respondents either had hospital privileges or pending hospital privileges. This is an increase from the 80% noted on the 2012 Task Analysis. 45.4% had hospital privileges through Medical staff and 15.8% through Allied Health staff. Of concern, 16.7% of respondents did not know through what mechanism they had hospital privileges. 94% of respondents reporting having prescriptive privileges, a small increase from the 90% who reported this on the 2012 Task Analysis. This is not surprising given that all state laws allow for CNM prescriptive practice, although there are a variety of state-specific requirements

affecting the degree of independent prescribing and the timeframe for obtaining independent prescriptive privileges (Osborne, 2015). Future analyses may clarify the level of independent prescribing privileges new CNMs/CMs have attained.

All respondents were employed in midwifery and reported providing care across the six midwifery practice areas. 93.4% indicated providing antepartum care, 89.1% indicated providing intrapartum care, 81.9% indicating providing postpartum care, and 76.7% indicated providing well woman/gynecological care. These responses closely resemble the percentages of midwives providing care in corresponding practice areas in the 2012 Task Analysis survey. Of interest, in the 2012 Task Analysis survey, 72.1% indicated providing newborn care while in the current Task Analysis only 18.7% indicated providing newborn care. This discrepancy may be due to wording of the newborn task items on the current task analysis that resulted in respondent confusion about the timing of the newborn care they provide. Future task analyses should clarify the timing of newborn care tasks, whether they are performed in the immediate postpartum period or over a longer time period.

The proportion of CNMs/CMs providing primary care has continued to decline over the past three task analyses. In 2007, 47.5% of CNMs/CMs reported providing primary care. This percentage dropped to 46.1% in 2012 and 31.9% in the current task analysis. It is unclear if this trend is due to an actual decrease in primary care services provided by midwives or due to the desire to decrease respondent burden by only providing primary care survey tasks to those who indicated they provided primary care in their practice. It may be that CNMs/CMs do provide primary care but that they do it in the context of other practice areas. This may then possibly result in the belief that the midwife does not provide that care. Future task analyses may provide clarity on this issue by including primary care tasks for rating by all respondents instead of only to those who indicate they provide primary care services.

Midwives continued to indicate that they provide care for abnormal as well as normal conditions. It is well known that midwives frequently provide care for at-risk women, and that the quality of the care provided is comparable, if not better, to the care provided by obstetricians (World Health Organization, *n.d.*; Sandall, Soltani, Gates, Shennan, & Devane, 2016; Renfrew et al., 2014; Thornton, 2017). In the 2012 Task Analysis, respondents estimated that over 41% of

their patients had abnormal conditions. This estimation increased to 48.4% of patients having abnormal conditions in the current task analysis. This finding calls for reconsideration of the amount of abnormal content taught in midwifery education programs, as well as for consideration of including additional abnormal content in the ACNM Core Competencies. This trend towards increased midwifery care of abnormal conditions should continue to be evaluated in future task analyses.

Clinical Tasks

Review of clinical tasks revealed that 44 out of a total of 241 tasks should be considered for elimination from the certification examination blueprint based upon unweighted composite scores alone. Scores on these items demonstrated the tasks to be of both low importance and frequency, with unweighted composite scores falling below a cut-point score of 5. After discussion, the AMCB Research Committee recommended 23 tasks (9.7%) be considered for elimination; 15 fewer than the 38 (17%) tasks recommended in the 2012 task analysis. The AMCB Board of Directors subsequently approved the elimination of a total of 18 tasks (7.6%) from the certification examination blueprint.

Antepartum Tasks

A total of 45 antepartum tasks were included in the task analysis (Table 31). *Orders/obtains/interprets laboratory tests to determine baseline values and deviations from normal* had the highest unweighted composite score (8.94) followed by *identifies deviations from normal pregnancy*; *develops a management plan to respond to deviations*; *consults and/or refers as necessary* (8.91). Five items scored below the unweighted composite score of 5. Of these, 4 related to the performance of sonography: *performs sonography for amniotic fluid volume, presentation, and/or placental location* (4.92), *performs sonography independently to establish or confirm gestational age* (4.33), *performs biophysical profile* (3.44), and *performs sonogram to rule out fetal abnormality* (3.17). Research committee team members recommended removal of two of the four tasks: *performs sonogram to rule out fetal abnormality* (3.17) and *performs biophysical profile* (3.44). The fifth item falling below the unweighted composite score of 5 was *provide group or Centering Pregnancy™* care (4.16), which was recommended for retention by the Research Committee.

After discussion by the AMCB Board of Directors, the item *performs sonogram to rule out fetal abnormality* (3.17) was selected for elimination because it was not clear to which trimester this skill referred, and because performing the fetal anatomy survey is considered a technically advanced ultrasound and is not within the scope of midwifery clinical practice without obtaining additional credentialing (American College of Nurse Midwives, 2012a). The AMCB Board of Directors decided to retain the sonography items *performs sonography for amniotic fluid volume, presentation, and/or placental location* (4.92), *performs sonography independently to establish or confirm gestational age* (4.33), and *performs biophysical profile* (3.44) because of their inclusion within the scope of midwifery clinical practice, the increasing availability of sonography training opportunities for midwives, and the likelihood that these types of sonograms may be performed by midwives more frequently in the future.

Intrapartum Tasks

The task analysis survey included a total of 60 Intrapartum tasks (Table 32). Eight tasks were noted to have unweighted composite importance scores that fell below a cut-point score of 5. While unweighted composite importance scores were low (less than 5) for *delivers baby in breech presentation* (3.52) and *delivers baby in face position* (3.81), these tasks were recommended by the AMCB Research Committee for retention because of the importance of having the skills to respond appropriately when faced with delivery of either malpresentation. Because CNMs/CMs often work in settings where another obstetric provider is not immediately available, the task *delivers baby with vacuum* (3.07) was also recommended for retention, despite a low frequency score of 1.05. This low frequency score for vacuum delivery may be reflective of the settings of survey respondents.

After initial consideration, five intrapartum tasks were recommended to the AMCB Board of Directors for consideration for elimination, three of which were: *repairs 4th degree lacerations* (2.87), *repairs lacerations of the cervix* (3.08), and *repairs 3rd degree lacerations* (3.48). There was a significant difference in unweighted composite importance scores between *repairs episiotomy and/or 1st or 2nd degree lacerations of the perineum* (8.68) and the other laceration repairs, specifically *repairs 3rd degree lacerations* (3.48), *repairs 4th degree lacerations* (2.87), and *repairs lacerations of the cervix* (3.08). Frequency scores between *repairs episiotomy and/or*

1st or 2nd degree lacerations of the perineum (4.73) were significantly higher compared to the frequency scores for *repairs 3rd degree lacerations* (1.3), *repairs 4th degree lacerations* (1.0), and *repairs lacerations of the cervix* (1.08). The lower importance scores were likely directly related to the low frequency with which CNMs/CMs are performing 3rd, 4th, and cervical laceration repairs; therefore, these three items were recommended to the AMCB Board of Directors for elimination. It should be noted that while performance of perineal repairs beyond 2nd degree and of the cervix are not frequently performed by CNMs/CMs, identification of the presence of such lacerations remains an important task for the midwife.

The final two intrapartum tasks recommended to the Board of Directors for consideration for elimination were *delivers baby with* forceps with a low frequency (1.01) and unweighted composite importance score below 5 (2.76) and *administers pudendal anesthesia* (3.19). While *administers pudendal anesthesia* (3.19) fell well below the selected cutpoint of 5 and was recommended to the AMCB Board of Directors for elimination, the consensus of the Board was to retain this item because providing pudendal anesthesia is an important option for women birthing in settings where an epidural is not feasible or available.

Postpartum Tasks

A total of 15 postpartum tasks were included in the task analysis survey (Table 33). Of these, only one task, *lance external thrombosed hemorrhoids* (3.34), scored below the unweighted composite score of 5 and was recommended to the AMCB Board of Directors for elimination from the certification examination blueprint. This item was also recommended for elimination in the 2012 task analysis. Recommended treatment for external thrombosed hemorrhoids includes sitz bath, stool softener, and oral analgesics (Halverson, 2007); therefore, midwives may opt for this management instead of surgical treatment. Also, thrombosed hemorrhoids are believed to occur infrequently and may not be easily recognized by some healthcare practitioners (physicians and medical students) as indicated in a study by Grucela et al., (2010). The AMCB Board of Directors agreed with the recommendation to eliminate this task from the exam blueprint.

Newborn

There were a total of 30 newborn tasks included in the task analysis survey (see Table 34). Five of these tasks scored below the unweighted composite score of 5. The item with the lowest score, *performs male infant circumcision* (3.21), was recommended to the AMCB Board of Directors for elimination. This item was rated low in the previous task analysis and requires additional advanced training to perform. The other four tasks: *manages infant who requires phototherapy* (3.71), *performs infant intubation with laryngoscope* (3.97), *orders immunization during the neonatal period* (4.35), and *manages well baby visits past 1 week of age* (4.84) were recommended for retention by the Research Committee. It was decided by the AMCB Board of Directors that although only limited management of newborns was performed in some institutions due to the availability other pediatric healthcare providers, midwives in in home birth settings, birth centers, and some hospitals may be the main newborn care provider and therefore these tasks should be retained.

Well-Woman/Gynecology

There was a total of 58 well-woman/GYN tasks included in the task analysis survey (see Table 35). A total of 19 well-woman/GYN items scored at or below the unweighted composite score of 5, prompting the Research Committee to consider recommending these items to the AMCB Board of Directors for elimination. Change in consumer demand, interest, and availability of some tasks (i.e., *counsels and refers woman for the cervical cap method of contraception* (3.92), *provides cervical cap fitting and instruction* (3.63), *evaluates for and performs Essure and/or Adiana permanent sterilization* (3.34)), or need for training beyond basic midwifery education for others (e.g., *performs colposcopy* (3.61), *performs endocervical curettage* (3.5), *performs sexual assault examination* (3.96), *performs gynecological sonogram* (3.38), *first assists at GYN surgery* (2.98)) was the basis for the Research Committee's recommendation for elimination of these eight items. However, two of these items (*counsels and refers woman for the cervical cap method of contraception* (3.92) and *provides cervical cap fitting and instruction* (3.63) were subsequently retained by the AMCB Board of Directors to foster full access to contraceptive methods for women served by midwives. A ninth task, *performs artificial insemination* (3.25), was also recommended for consideration for elimination by the Research Committee and selected for elimination by the Board of Directors because it

lacked clarity given the range of tasks potentially associated with the care. This later task should be reconsidered for inclusion in the next task analysis (e.g., *performs intrauterine insemination*, *counsels regarding use of ovulation kits*, and *prescribes fertility medications*).

There were an additional 10 well-woman/GYN tasks that fell below the cut-off value of a composite score less than 5, suggesting the need to consider recommendation for elimination. However, following robust discussion by research committee members, the decision was made to recommend retention of the tasks. Well-woman/GYN tasks that were retained despite a low unweighted composite score included *removes condyloma using chemical methods* (4.97), and *treats condyloma using cryotherapy* (4.12). While the later item was repetitive of the first, the ability to use inexpensive, effective methods to remove condyloma— particularly in low resource settings, is important. *Provides diaphragm fitting and instruction* (4.3) was also recommended for retention. While diaphragm use has steadily waned since introduction of oral contraceptives pills (OCPs) in the 1960s, it is less expensive than OCPs, IUDs, or sterilization, allows for greater sexual spontaneity and sexual sensation then use of male condoms, provides moderate protection against sexually transmitted infections, is safer for women with certain medical conditions and women older than 35 years who smoke, is easily reversible, is female controlled, and does not require multiple provider visits each year (Allen & Cardsten, 2004). Approximately 0.1% of the female contracepting population in the US were using a diaphragm in 2010 (Daniels, Daugherty, Jones & Mosher, 2015) and though product availability has been an issue, it remains an important option for select populations. One item, *provides paracervical block for IUD insertion* (3.63), was of low frequency ("less than once or twice a year") with respondents rating it as "somewhat important to important." While not used much in the US for labor analgesia, paracervical block is useful in providing analgesia during gynecological procedures involving cervical dilation and/or manipulation. The increasing use of IUDs for contraception results in a concomitant increased rate of complications, including difficult IUD insertions and removals, for which paracervical may be useful (Tangsiriwatthana, Sangkomkamhang, Lumbiganon, & Laopaiboon, 2013).

Another gynecologic task recommended for retention despite having an unweighted composite score of less than 5 was *performs endometrial biopsy* (4.65), an office-based skill

important in ruling out endometrial hyperplasia or cancer in at-risk populations. Two groups at particular risk are obese and older women. As the obesity epidemic continues to grow and the population of older women continues to increase (Robert Woods Johnson Foundation, 2016; Ortman, Velkoff & Hogan, 2014), this skill will be essential for midwives to provide effective early intervention. Similarly, *performs vulvar biopsy* (4.09) is an essential skill in the early diagnosis of vulvar cancers. Vulvar cancers increase with age and there is an increasing incidence in young women because of its association with human papillomavirus (American Society of Clinical Oncology, 2017). Early diagnosis is important to survival, thus as primary care providers, midwives play an essential role in both early detection and treatment.

Additional items recommended by the research committee for retention were *orders sonohystogram* (4.48) and *prescribes pharmaceuticals for treatment of infertility* (4.59). Sonohystograms are often recommended to ascertain the cause of heavy bleeding, repeated miscarriages, or where there is difficulty conceiving when regular ultrasound has failed to delineate the etiology. Heavy menstrual bleeding is one of the most common gynecologic disorders affecting women of reproductive age with an incidence of 10-35% of U.S. women (Marsh, Brocks, Ghant, Recht, & Simon, 2014). Recurrent miscarriage affects 1% of women trying to conceive (Rai & Regan, 2006). Women having difficulty conceiving are often first treated with pharmaceuticals when ovulation is irregular or absent. Diagnostic testing and the use of pharmaceuticals to promote the successful conception and carrying of an infant to term are important tasks for the midwife primary care provider.

Two final well-woman/GYN tasks with unweighted composite scores of less than 5 that were discussed and subsequently recommended for retention by the research committee were *pre-hysterectomy and post-hysterectomy counseling* (4.05) and *medically manages ectopic pregnancy (i.e., methotrexate)* (4.25). Hysterectomy is a relatively common procedure in the US with a rate of 5.4 per 1,000 women (Domingo & Pellicer, 2009). The need for hysterectomy may stem from a wide variety of gynecologic disorders managed by midwives including abnormal uterine bleeding, uterine prolapse, and chronic pelvic pain. Skill in counseling women both before and after hysterectomy is crucial for patient decision-making and quality of life. Finally, ectopic pregnancy, a potentially life-threatening condition, accounts for approximately 1-2% of

all pregnancies with an incidence that has increased 6-fold since 1970 (Sepilian, 2016). While historically treated with surgery, as many as 35% of women with ectopic pregnancies are now medically managed (Hoover, Tao & Kent, 2010). Prompt treatment and close follow-up is essential knowledge for midwives.

Primary Care

Thirty (30) primary care tasks were included in the task analysis, with six tasks receiving an unweighted composite score of less than 5 and thus considered for elimination (see Table 36). Review of these tasks by Research Committee members resulted in a recommendation to the AMCB Board of Directors to eliminate these items from the test blueprint. Items recommended for removal included *performs breast biopsy* (3.09), *performs skin biopsy* (3.57), *performs removal of abnormal lesions (e.g., skin tags, nevus) as indicated (e.g., cautery, scalpel, liquid nitrogen)* (4.15), *performs cortisone injections* (3.01), *evaluates and treats minor wounds* (4.86), and *sutures minor wounds* (3.98). Many of these tasks are referred to other specialists including dermatology, orthopedics, internal medicine, and family medicine. In addition, all of these items address diagnosis and/or treatment rather than screening or counseling except *sutures minor wounds* (3.98), which was the only item subsequently retained by the AMCB Board of Directors.

Free-Form Responses

Each section allowed for respondent comments about the tasks listed in each area of clinical midwifery practice (Appendix L). The following sections relate to respondent comments specific to each practice area, including recommendations for tasks to include in future task analyses.

Antepartum

The importance of skills related to working in collaborative teams was mentioned by several respondents. Suggestions were made to include future tasks related to managing team dynamics and addressing the importance of co-managing and referring women with higher risk conditions. These suggestions are timely given that *Partnership* is one of ACNM's Core Values (American College of Nurse Midwives, 2012b), many midwives practice in a collaborative team context, and there is expected to be an increase in the number of interprofessional collaborative relationships between midwives and physicians in the near future (Smith, 2016).

Additional suggestions for future tasks included caring for women with higher risk conditions, screening for depression, gestational weight gain counseling, pharmacologic management of acute and chronic health conditions in pregnancy, and providing counseling for women who decline medical recommendations for intervention. Some respondents noted that the lack of context made it difficult for them to score tasks as their responses would vary depending on the context in which the task occurred; and others mentioned that some items asked about skills beyond those included in ACNM's Core Competencies and that as new providers they hadn't yet had the chance to expand the scope of their practice.

Intrapartum

The increasing utilization of nitrous oxide for intrapartum pain management warrants including this task in future task analyses (Likis et al., 2014). As CNMs/CMs may employ manual rotation of the occiput posterior fetus to correct fetal malposition and potentially reduce the need for operative delivery (Masturzo et al., 2017), the addition of this task as well as the use of sonography to determine or confirm fetal position in labor or in the case of prelabor rupture of membranes should be considered for inclusion in future task analyses.

Postpartum

Several respondents identified the lack of inclusion of tasks addressing birth control/contraceptive options in this section and clearly stated the need for related tasks to be included. The use of long acting reversible contraceptives (LARCs) including subdermal contraceptive implants, injections, and intrauterine devices (IUDs) is becoming increasingly popular and is recommended by ACOG (2016b) for use during the immediate postpartum period to reduce unintended pregnancy and short interpregnancy intervals. There were also suggestions to include the evaluation of psychosocial status and postpartum support systems, as well as tasks addressing the initiation of care for postpartum depression/psychological disorders. A few comments focused on co-management of post-operative cesarean section patients. The argument for adding tasks addressing the co-management of patients with cesarean sections stems from the reality that some midwifery patients may birth by cesarean section and may be collaboratively managed. Midwives may also see postpartum patients for staple removal and wound checks during the postpartum period.

Newborn

Comments in this area were concerned with the fact that responsibility for newborn care varied depending on clinical setting or geographic location. Although these tasks may be performed by midwives, they may also be provided by "pediatric specific providers" including nurses and physicians. These comments are consistent with previous task analysis findings that many midwives do not regularly provide newborn care. Although newborn care may only be provided infrequently, it is very important that midwives know how to perform the associated tasks as they are within the core competencies of basic midwifery practice (American College of Nurse-Midwives, 2012c). After discussion, Research Committee team members agreed that some of the tasks in this section were likely interpreted by respondents as addressing longer-term care of newborns as opposed to providing immediate post-delivery newborn care and that this should be clarified in future task analysis surveys.

Well-Woman Gynecology

Respondents made particular note of practice variation based on clinical setting, restrictions on midwifery practice, confusion over item wording, and the need for clearer definitions of terms (e.g., collaboration). Several suggestions were made for additional well-woman/GYN tasks to be considered for future task analyses, including pessary fitting, affirming interactions with gender non-conforming individuals, and counseling for pregnancy options, including pregnancy termination. There were also suggestions to include weight loss counseling, substance abuse, depression screening and treatment, referral for abortion, post-abortion counseling, urinary tract infections, and assessment and counseling about treatment options for depression and anxiety. These later items were included in other practice areas of the task analyses but were not duplicated in the well-woman/GYN area in an attempt to reduce respondent burden. Addition of these tasks to this section should be considered in future task analyses. There were also comments demonstrating state or institutional practice restrictions which limited scope of care (e.g., not allowed to do GYN ultrasound or colposcopy, legal restrictions in treating males).

Primary Care

Few comments were made by respondents related to primary care tasks. Those that were received emphasized the need to add additional tasks such as diabetes screening, management of substance use disorders, and long-term management of mood disorders.

RECOMMENDATIONS

Based on results of this Task Analysis, the AMCB Research Committee and Board of Directors recommend the following:

1. Consider prospective study designs to ascertain tasks performed by newly certified CNMs/CMs in clinical practice. Retrospective survey studies, such as this task analysis, are known to have significant biases related to subject recall, and it is difficult to determine temporal relationships.
2. Reconsider approaches for improving response rates, including multimodal strategies (e.g., email and/or mailed options, telephone survey), differing compensation approaches, and email distribution strategies that could improve deliverable emails and verify that they are read.
3. Conduct a follow-up survey of non-respondents to better understand reasons for non-response and to identify potential differences between those who did and did not respond. Such follow-up would improve accuracy in the interpretation of survey findings and reduce study error.
4. Further consider strategies to reduce survey length. While this survey did significantly reduce length by deleting management of conditions across domains—an activity that had been done on prior task analyses, further reduction would likely increase response rates. One consideration would be to place frequency and importance items for each task on one screen.
5. Consider adding tasks to all domains where relevant. For example, depression, anxiety and mood disorders may be seen in all clinical practice areas. Addition of such items to all relevant domains would be especially important when respondents are not in full scope midwifery practice.

6. Add a completion (progress) bar to the online survey task analysis. This feature was not available in the current version of REDCap but could be added with use of HTML features should the feature not be available on future REDCap versions.
7. Consider deletion of the 18 clinical tasks that were of low frequency and importance and approved by the AMCB Board of Directors from the AMCB certification examination blueprint (Table 38).
8. Develop procedures that force summing to 100% for the item asking participants to assign a percentage to each area of midwifery practice for weighting certification examination items.
9. Consider the addition of more intrapartum, newborn, and primary care items and fewer items focusing on antepartum and well-woman/GYN care to the certification exam based on test weight specifications.
10. Differentiate tasks focused on immediate newborn care versus longer-term newborn care for purposes of clarification.
11. Consider structuring the certification examination to emphasize 48% normal and 52% abnormal conditions.

SUMMARY

The primary purpose of this task analysis was to identify clinical tasks performed by newly certified midwives to allow for the design of a certification examination based on those tasks. Identified tasks are also used to update the examination test specifications (how questions are weighted across each area of practice) so that knowledge and skills related to those critical tasks are reflected on the certification exam and are consistent with the clinical practice of new certificants. Data are also used to inform the weighting of normal versus abnormal conditions.

The 2017 Task Analysis surveyed nurse-midwives and midwives who were certified by the AMCB between 2013 and 2016. The survey was administered online with an overall response rate of approximately 25%. Utilizing one truncated survey form, certificants were queried regarding the clinical tasks performed across the six areas of midwifery practice. Additionally, respondent recommendations were sought for how the certification examination should be weighted across the six practice areas, as well as normal and abnormal conditions.

Results from this survey provide evidence of the need to reconsider inclusion of 18 tasks in the certification test blueprint. Test specifications for five of the six areas of midwifery practice should also be reconsidered with an increase in intrapartum, newborn, and primary care items and fewer items focused on antepartum and well-woman/GYN care. Additionally, data from this research suggests the need to reconsider the weighting of normal and abnormal conditions with a significant increase in the later.

The mission of the AMCB is to protect and serve the public by assuring that individuals who are credentialed as Certified Nurse-Midwives (CNMs) and Certified Midwives (CMs) have met established standards (American Midwifery Certification Board, *n.d.*). Central to that mission is developing and administering a certification examination that determines whether CNMs/CMs have attained the competencies necessary for safe and effective entry-level practice. Results from this task analysis provide data that are crucial to meet this mission.

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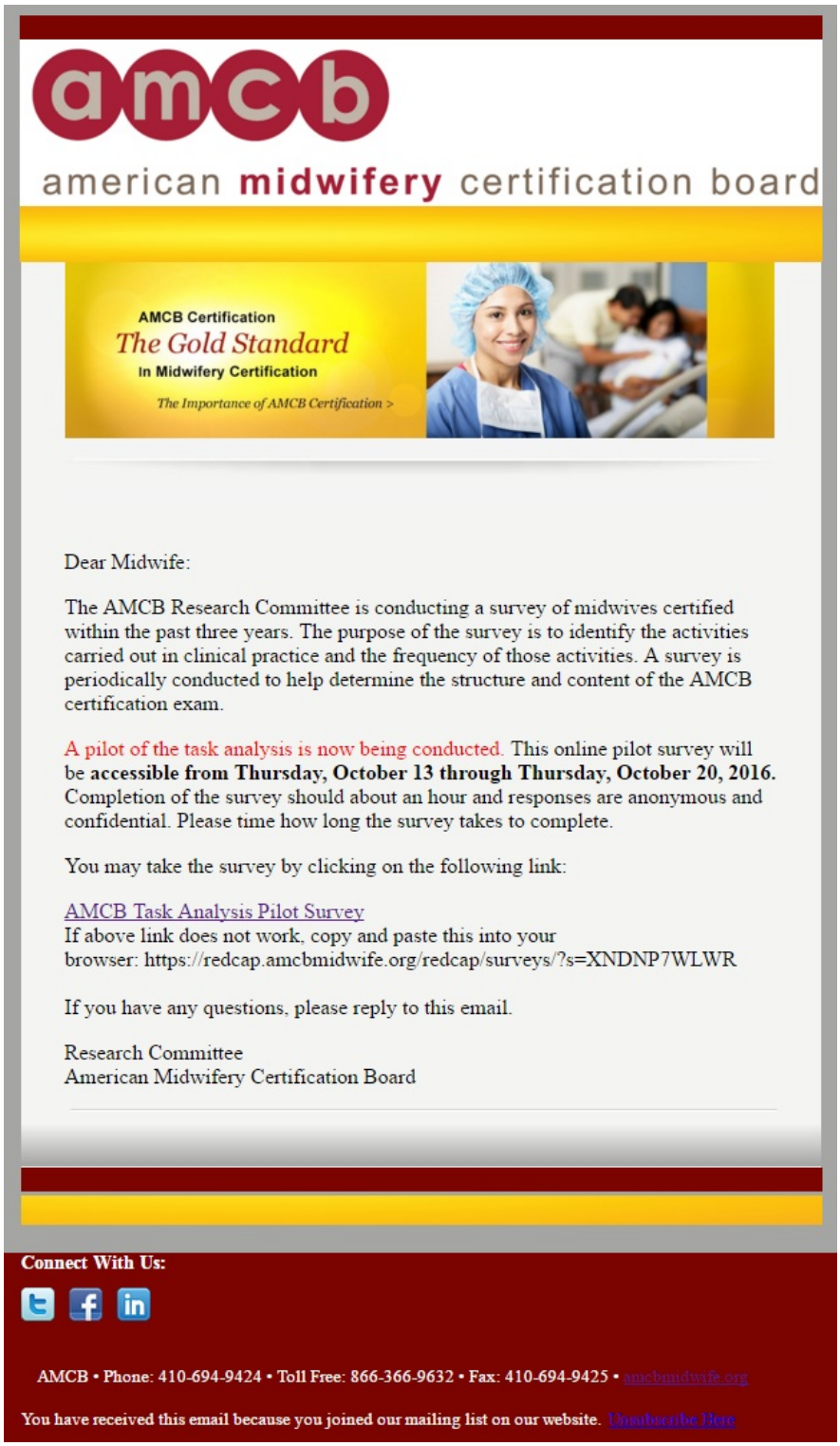
APPENDIX A. RESEARCH COMMITTEE TEAM

Name	Credentials	Position outside of AMCB	Expertise	Year of Initial AMCB Certification	ACNM Membership Region
Barbara McFarlin	CNM, PhD, RDMS, FACNM, FAAN	Associate Professor, University of Illinois at Chicago	Clinical practice, research, midwifery educator, ultrasound practice	1984	4
Cathy L. Emeis	CNM, PhD	Assistant Professor, Oregon Health & Science University	Clinical practice, research, midwifery educator, quality improvement	1998	7
Elizabeth Pickett	CM, MS, LM	Midwife, Refuah Health Center, Monsey NY Total Care Midwifery, private practice, New Paltz, NY	Full scope midwifery practice	2013	1
Marie Hastings-Tolsma	CNM, PhD, FACNM	Professor Baylor University, Louise Herrington School of Nursing Dallas, TX	Clinical practice, research, midwifery educator, clinical midwifery outcomes	1996	6
Joyce Hyatt	CNM, PhD, DNP	Associate Professor, Rutgers Biomedical and Health Sciences University, Newark, NJ	Midwifery educator, clinical practice	1995	2
Tanya Tanner	CNM, PhD, MBA, APRN, FACNM	Assistant Professor, Frontier Nursing University	Clinical practice, physiologic birth, research, distance midwifery education	1996	6

APPENDIX B. PSYCHOMETRICIAN BIOGRAPHY

Dr. Tina Freilicher, Ph.D. is a measurement consultant in the areas of credentialing and accreditation. She has more than 30 years of experience developing certification, licensure, registration and employee selection examination programs for a variety of domestic and international professional organizations and/or regulatory agencies. She has extensive experience conducting job analyses, developing competency frameworks, test specifications, item and examination development, and standard setting. Dr. Freilicher has managed the development and implementation of high-stakes and large-scale examination programs. She works with certifying bodies to ensure that examination programs are developed and maintained according to best practices in the testing industry. Dr. Freilicher has a Ph.D. in Measurement and Evaluation from Columbia University. Her doctoral dissertation was on passing point methodology (i.e., Freilicher, T.M. (2005). A comparison study of standard setting methods using test score data for a medical competency simulation examination (Doctoral dissertation, Columbia University, 2005). ProQuest Information and Learning Company, UMI Number 3159737). Dr. Freilicher is the owner of Shoreline Psychometric Services, LLC.

APPENDIX C. E-MAIL INVITATION TO PILOT PARTICIPANTS



amcb

american midwifery certification board

AMCB Certification

The Gold Standard

In Midwifery Certification

The Importance of AMCB Certification >

Dear Midwife:

The AMCB Research Committee is conducting a survey of midwives certified within the past three years. The purpose of the survey is to identify the activities carried out in clinical practice and the frequency of those activities. A survey is periodically conducted to help determine the structure and content of the AMCB certification exam.

A pilot of the task analysis is now being conducted. This online pilot survey will be **accessible from Thursday, October 13 through Thursday, October 20, 2016.** Completion of the survey should about an hour and responses are anonymous and confidential. Please time how long the survey takes to complete.

You may take the survey by clicking on the following link:

AMCB Task Analysis Pilot Survey
If above link does not work, copy and paste this into your browser: https://redcap.amcbmidwife.org/redcap/surveys/?s=XNDNP7WLWR

If you have any questions, please reply to this email.

Research Committee
American Midwifery Certification Board

Connect With Us:

AMCB • Phone: 410-694-9424 • Toll Free: 866-366-9632 • Fax: 410-694-9425 • amcbmidwife.org

You have received this email because you joined our mailing list on our website. Unsubscribe Here

APPENDIX D. INITIAL E-MAIL INVITATION TO MAIN STUDY PARTICIPANTS

Subject: AMCB Task Analysis Survey

Dear Midwife:

The AMCB Research Committee is conducting a survey of midwives certified from September 2013 to September 2016. The survey is conducted every five years.

The purpose of the survey is to identify tasks newly Certified Nurse-Midwives/Certified Midwives perform in practice. **Participation in the Task Analysis is very important as results are used to determine the types of questions that appear on the AMCB Certification Examination in Nurse-Midwifery/Midwifery.**

This online survey is now available through November 28th and can be completed in more than one sitting.

Completion of the survey will take about 1 hour and individual responses are anonymous and confidential.

Those who successfully complete the survey will be given 10 contact hours towards AMCB recertification and are eligible to enter a drawing for 1 of 10 gold 32GB WiFi iPad mini4s. Early completion of the Task Analysis survey gives you up to 10 chances to win. Completion of the survey in the second week gives you up to 6 chances to win. Completion in the third and final week gives you up to 3 chances to win.

We appreciate that you are taking the time to complete the survey. It is important to our profession!

Should you have any questions or technical difficulties, please contact Lori Havens, survey coordinator, at lhavens@amcbmidwife.org.

Thank you.
AMCB Research Committee
You may open the survey in your web browser by clicking the link below:
Task Analysis Survey

If the link above does not work, try copying the link below into your web browser:
https://redcap.amcbmidwife.org/redcap/surveys/.....

This link is unique to you and should not be forwarded to others.

APPENDIX E. FOLLOW-UP E-MAIL INVITATION REMINDER TO MAIN STUDY PARTICIPANTS

Subject: AMCB Task Analysis Survey: Reminder

Dear Midwife:

This is a reminder to complete the 2017 Task Analysis from the AMCB. Participation in the Task Analysis is very important as results are used to determine the types of questions that appear on the AMCB Certification Examination in Nurse-Midwifery/Midwifery.

As a thank you, those who successfully complete the survey will be given 10 contact hours towards AMCB recertification and are eligible to enter a drawing for 1 of 10 gold 32GB WiFi iPad mini4s! (Second Reminder: Four winners have already been selected for the first week; complete the survey now for a chance to win one of the remaining 6.)

This online survey is now available through November 28th and can be completed in more than one sitting.

The survey will take about 1 hour to complete. Individual responses are anonymous and confidential.

We appreciate that you are taking the time to complete the survey. It is important to our profession!

Should you have any questions or technical difficulties, please contact Lori Havens, survey coordinator, at lhavens@amcbmidwife.org.

Thank you.
AMCB Research Committee

You may open the survey in your web browser by clicking the link below:

Task Analysis Survey

If the link above does not work, try copying the link below into your web browser:

https://redcap.amcbmidwife.org/redcap/surveys/.....

This link is unique to you and should not be forwarded to others.

APPENDIX F. TASK ANALYSIS SURVEY DIRECTIONS

AMCB Task Analysis Survey Instructions:

Thank you for taking the time to complete this survey. Your time and responses are greatly appreciated.

This survey, created by The American Midwifery Certification Board, describes tasks performed by CNMs and CMs who practice in the United States. Our intent is to identify tasks new midwives actually perform and to use this information to help us make the AMCB certifying examination reflective of these tasks.

The survey will take about 1 hour to complete. You are asked to make judgments about specific tasks, keeping YOUR practice in mind. Please read each task carefully and then rate each task according to the instructions provided per section. The survey has several sections but you will only be completing those sections related to the areas of midwifery that you are currently providing care. You may skip any items that you wish.

When you are finished with a page, click "Next". Continue until the last page where you can click "Submit".

NOTE: If you leave the survey and plan to complete it at a later time, you must click "**SAVE AND RETURN**". You will be given a code to use when you return. If you are returning to the survey, please click the "RETURNING?" in the upper-right corner of this page.

When taking the survey **DO NOT CLICK** the "back" button in your browser. If you wish to return to the previous screen, please click "Previous Page".

Completion of this questionnaire constitutes your informed consent to act as a participant in this research. The survey is anonymous and your name will not be linked to your responses.

By participating in this survey you will be providing a valuable service to your profession. Please accept our sincere thanks.

AMCB Research Committee

APPENDIX G. ACNM QUICK E-NEWS ADVERTISEMENT

Help AMCB maintain the gold standard by completing the Task Analysis survey for 10 contact hours and the chance to win a gold iPad!

The American Midwifery Certification Board (AMCB) is conducting a TASK ANALYSIS of certified CNMs/CMs in November 2016. The task analysis targets those CNMs/CMs who have been certified in the past 3 years --- September 2013-September 2016, and looks to determine those tasks that these midwives perform in clinical practice. Findings are used to develop the certification exam which is required for midwifery practice in the U.S.

CNMs/CMs certified between September 2013 and September 2016, should watch for an email of invitation from the AMCB on November 7th. The online survey takes approximately 1 hour to complete and will be open until November 28th. Those who successfully complete the survey will be given 10 contact hours towards AMCB recertification and are eligible to enter a drawing for 1 of 10 gold iPad mini4s.

Watch for the AMCB email of invitation!

amcb
american midwifery certification board

APPENDIX H. ACNM QUICK E-NEWS ADVERTISEMENT CONDENSED

Complete AMCB's Task Analysis survey for the chance to win!

AMCB

The American Midwifery Certification Board (AMCB) is conducting a task analysis of certified CNMs/CMs during November 2016. The analysis targets those CNMs/CMs who have been certified in the past 3 years, Sept. 2013 through Sept. 2016. Its goal is to determine the tasks midwives perform in clinical practice. Findings are used to develop the certification exam, which is required for midwifery practice in the US. If you've been certified during this time, watch for an email invitation on Nov. 7. Please complete the 1 hour survey before Nov. 28. For your help, you'll be given 10 contact hours towards AMCB recertification and are eligible to enter to win 1 of 10 iPad minis. READ MORE

APPENDIX I. ANNOUNCEMENT FOR PROGRAM DIRECTORS

Greetings from your Midwifery Program Director!

The American Midwifery Certification Board (AMCB) is conducting a TASK ANALYSIS of certified CNMs/CMs in November 2016. The task analysis targets those CNMs/CMs who have been certified in the past 3 years (September, 2013-September 2016), and looks to determine those tasks that these midwives perform in clinical practice. **It is very important that you complete this survey, as findings are used to develop the certification exam which is required for midwifery practice in the U.S.**

CNMs/CMs certified between September, 2013 and September 2016 should watch for an email of invitation from the AMCB on November 7th. The online survey takes approximately one hour to complete and will be open until November 28th. Those who successfully complete the survey will be given 10 contact hours towards AMCB recertification and are eligible to enter a drawing for 1 of 10 gold iPad mini4's.

Watch for the AMCB email of invitation! If you do not receive the email invitation, please contact Lori Havens at AMCB (LHavens@amcbmidwife.org).

APPENDIX J. AMCB WEBSITE ANNOUNCEMENT

http://www.amcbmidwife.org/about-amcb/task-analysis

2017 Task Analysis Announcement:

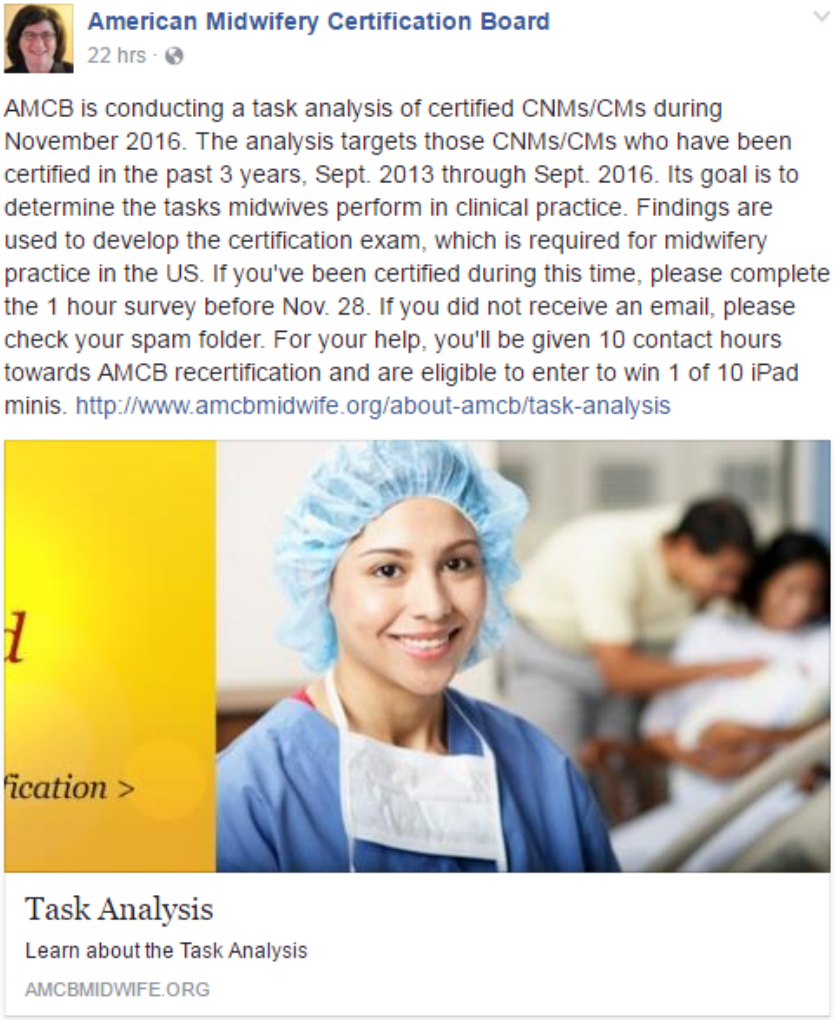
Help AMCB maintain the gold standard by completing the Task Analysis survey for 10 contact hours and the chance to win a gold iPad!

The American Midwifery Certification Board (AMCB) is conducting a TASK ANALYSIS of certified CNMs/CMs in November 2016. The task analysis targets those CNMs/CMs who have been certified in the past 3 years --- September 2013-September 2016, and looks to determine those tasks that these midwives perform in clinical practice. Findings are used to develop the certification exam which is required for midwifery practice in the U.S.

CNMs/CMs certified between September 2013 and September 2016, should watch for an email of invitation from the AMCB on November 7th. The online survey takes approximately 1 hour to complete and will be open until November 28th. Those who successfully complete the survey will be given 10 contact hours towards AMCB recertification and are eligible to enter a drawing for 1 of 10 gold iPad mini4s.

Watch for the AMCB email invitation!

APPENDIX K. AMCB FACEBOOK POST



APPENDIX L. ACCUMULATED SUBJECT FREE-FORM RESPONSES BY AREA OF MIDWIFERY PRACTICE

Antepartum Comments

A group of OB/GYNs are my back up group of doctors. We seldom are able to let patients opt for a VBAC unless they come in laboring. Also, all of the dating ultrasounds are done by the OB doc along with BPP and to evaluate fetal growth.

Because we work in collaborative teams, some of these skills are less 3 to know as a midwife, as long as you have someone to refer to.

clearly caring for women developing higher risk issues (hypertension/GDMA2) is 3 but seems most 3 to know when to refer appropriately . . . the phrasing of these questions/statements is confusing.

Counseling and management of pregnant women with history of poor fetal outcomes, or history of complicated pregnancy and/or complicated delivery. Management of pharmaceuticals during pregnancy - whether related to pre-existing condition (i.e.; anxiety, depression, etc.) or acute condition (i.e.; STD, bronchitis, etc.)

Creates a relationship of trust with her client

I believe it is 4 to evaluate for diabetes in pregnancy, however, I don't think it is 4 for me to manage it. We have our MFM manage the diabetes education and monitoring and accept their recommendations.

I believe that a CNM need to know what is normal and what is not, if the CNM recognize this is not normal, she needs to refer to a specialist

I care for high risk women and out of hospital birth isn't an option. I do not feel like the ability to perform a BPP is as 3 as being able to order one. I am not able to spend the time to do a BPP in office as I see too many patients.

I practice in a setting where VBACs, GDMs, and other high risk pregnancies are predominantly managed by a doc, only seeing midwives occasionally when a change in schedule dictates.

I regularly evaluate patients for diabetes, but I do not manage them if they are diagnosed with it.

I should not need to answer the level of importance for the questions on the previous page that I stated were not applicable to my practice.

I think CNM and MD collaboration is 4-knowing how to advocate with and for your patients but also to be an active and respectful team player. How to be a voice but not an irritant. Difficult to write questions about this--but it's an 3 part of integrating evidence-based and safe practice in our field!

I think it would be good to add a question regarding Depression Screening in the Antepartum and Postpartum period.

I think it's most 3 for new midwives to figure out normals in the first 5 years. If there are abnormals or extra skillsets, I don't think it's as 3 to have mastered these yet.

It would be very useful to my practice if I was able to perform US examinations for gestational age and BPP, however, my training did not prepare me to do this. And alas in my first year of practice I have not had the time or opportunity to learn these skills.

Never do pelvimetry. Ever.

Our practice has guidelines for consultation and referral to our back-up OB practice for some of the conditions mentioned, in particular non-diet controlled GDM, hypertensive disorders, breech presentation at 36 weeks. We also refer to MFM for genetic counseling. In our practice, it is usually an RN's role to do an intake interview, order initial prenatal labs, do an initial dating assessment, and order an early ultrasound if indicated.

PIH should possibly read gestational hypertension.There is the new information regarding pelvic exams.

Please consider adding the importance of counseling women on appropriate and excessive gestational weight gain in regard to BMI at the beginning of pregnancy and throughout.

Question 19 is unclear. To clarify, if I had a patient considering termination I would counsel her against aborting her baby. That is 4. But the way the question reads it is unclear if you are asking if I would present abortion as an option to a woman with an unplanned pregnancy.

SAB and IUFD are often managed by our physicians, but this is an 3 task that I should be competent in. Options counseling and substance abuse/domestic abuse screening are 4 tasks as well, but not often used in my practice due to our demographic. Missing Tasks: (1) Counseling and recs based upon predicted fetal macrosomia and risks/benefits including shoulder dystocia (2) counseling on risks of declined recommendations or just counseling on risks & benefits of agreeing to or declining flu shot, Rhogam, GBS screening, GDM screening, etc. -this is a common and challenging task.

Screening for depression/anxiety/mood disorders is 4

There are instances listed above which differ case by case. For instance, I would not do a serial hcg on a low-risk patient who's pregnancy is progressing as expected. I would do this with someone who has been a habitual aborter.

Unsure what is meant by 'counseling' in relation to substace abuse and SAB/fetal demise. Long term counseling? or counseling only in the event? It's unclear.

We are a Christian hospital, majority of patients have to decide to continue the pregnancy prior to first visit with CNM I am certified in Ultrasound, but this hospital I work for does not have US in outpatient setting for us to use. This is referred out.

With a sonographer in house it is not as 3 for me to do US dating or BPP or screen for abnormalities.

Intrapartum Comments

Accompanies woman during intrapartum transport to a higher level facility (ex: hospital from home or birth center) for continuity and emotional support.

Again, I think it's 3 to be able to handle normal activities for a normal birth, but some other skills come with experience. Also, it needs to be recognized that depending on your work

environment, some skills may not even be allowed. My hospital does not allow for water birth. Pudendal blocks are not done at my hospital. Additionally, at my hospital, in the event that a midwife needs help, there is an OB in house to assist.

As I am currently doing births only at a birth center I do not currently perform some of these tasks at this time, but have in the past and expect to do so in the future. 3rd, 4th degree are not repaired at the birth center and would require a hospital transfer. We do not induce our VBACs.

Estimated blood loss measurement - should also read or quantitative blood loss measurement since that is the newfound recommendation for accuracy.

I believe the VBAC, waterbirth, and breech questions should have a qualifier of whether or not it is an option in the practice.

I do not repair 3rd and 4th degree lacerations.

I have immediate physician back-up if there is an emergency. We are going to train as first assists next month. Waterbirth is not an option.

If I answered 1, I meant, that its 1 I, as a midwife, do those things- not that they are 1

If I marked 1 it is because I have the support of OBGYN that I would consult in those circumstances and they would manage.

In my group, VBACs, demises, and complicated pregnancies as well as postpartum complications are usually addressed by the doc who is on with the midwife.

In my setting we have OBs and residents on site at all times who handle some tasks

labor dystocia management

Nutritional needs of woman: Hospital still encourages NPO in labor, but we can independently order full diet and encourage snacks. Chorioamnionitis: we consult and comanage administration of antibiotics and then further management of labor (e.g. if CS becomes necessary). Pudendal anesthesia: not a skill that was learned but would be useful. Blood transfusion: only 3 insofar as we consult with our MDs to make a final decision. IOL of VBAC pts is 3: it is just that our practice guidelines do not allow for IOL of VBAC, just augmentation. Missing=manages the administration of narcotic analgesics during labor.

Perhaps a question regarding evaluation of fetal wellbeing using IA?

Quantified blood loss, not just estimated blood loss

Regarding waterbirth: I think it is an 3 skill, but the hospital where I have privileges does not currently officially permit the practice, so the only waterbirths that occur there are rare, 'accidental' ones (I've only been there for about 2 months and haven't had one yet). However, it's on my list of priority items to propose bringing to the hospital.

there needs needs to be an option to state, I have not done this yet, but am expected to perform this task. For instance I have hospital privileges but have not yet gone to the hospital. I had to answer 'I do not perform' when really I will be performing those tasks that are associated with the hospital.

use of sonography

We also use nitrous oxide for labor analgesia and see that as more institutions are offering this modality, it will be 3 for new grads to be familiar with its use in labor.

We are working on getting waterbirth privileges at our hospital. It is an uphill battle, not made easier by ACOG's continued 'expert opinion' statements. We also put in Cook and foley catheters pretty regularly for IOL, and that insertion I would put as a separate task from miso/cervidil.

Postpartum Comments

#2: Refers for LC was inaccurate for me to answer because I am an IBCLC myself. So I don't refer, I just do the lactation consultation.

4 part of my postpartum care: birth control counseling/family planning counseling! We are starting to do implants/Nexplanons PP in our hospital before women are discharged home.

Assess support system, i.e. how father of baby providing support, reaching out to other family or friends as needed. Create a support network i.e. with other new moms, with friends. Ask for help i.e. when people come over bring food, help around the house, assist with siblings.

Contraception and family planning advice and prescribing, inserting LARCs either at time of birth or in the later postpartum period. Initiating care for postpartum depression -- referring for talk therapy, initiating pharmaceuticals, reviewing efficacy, discussing CAM treatments including diet, exercise, lifestyle modifications. referring for social services in the postpartum period

I believe some of these are best served by other practitioners or in concert with other practitioners.

If/when my clients are post cesarean, I co-manage with the physician per hospital protocols. This usually equates physician response to my assessment, recommendations, and evaluation of the patient.

It's 3 to discuss birth control options that are available, even prior to their 6 week check up they should be educated about options available to them. Very few of the patients I see actually wait 6 weeks to resume sexual activity.

Management of perinatal mood disorders is so necessary-----daily/weekly patients!

Missing: Evaluates psychosocial status and PP support system making referrals and recommendations as indicated. Manages signs and symptoms of PP anxiety and depression including referring for counseling or prescribing pharmaceuticals as indicated. Discusses options for birth control and provides counseling making recommendations compatible with breastfeeding if needed.

Our c/s patients are seen by OB care in postpartum in hospital, but then come to us (CNM) for staple removal5-10 days post c/s. For me, it's 3 to know who to refer to for postpartum complications.

Prescribe postpartum pain management options. Discuss birth control options.

there should be a separate question regarding managing postpartum hypertension.

There wasn't mention of family planning method in postpartum

We do not have separate lactation consultants in our facility, instead the midwives are expected to provide all of the lactation services.

We work with a team of residents and OBs who address some of these areas instead of the midwives.

Newborn Comments

Many of these can be managed by pediatric specific providers.

Midwives should not be performing male infant circumcisions, since the patient cannot consent for himself. Parental assent should be reserved for medically necessary surgeries. Additionally, midwives are not surgeons nor are they experts in male genitalia. Finally, the basic human rights of male infants should be respected just as they are for female infants.

Most of my clients decline eye antibiotics. I recommend auditory screening and provide a list of places to get it done, but do not call in a referral (no one has ever indicated that they needed a referral).

Much of the newborn care in my practice is provided by nurses including evaluation of the infant and administration of ophthalmic ointment and Vitamin K. The pediatrician evaluates, assesses and manages the care of the infant.

There is a clear delineation of duties when it comes to newborn care in our facility between nurses, midwives and pediatricians. For example, (1) while I order chemoprophylaxis for opthalmic neonatorum, it is the nurse that administers it, (2) while I order bilirubin levels, it is the pediatrician who manages jaundice requiring phototherapy, and (3) NRP is largely a nursing task, although I am expected to initiate/assist as needed if sufficient nurses are not immediately available. I found the questions that lumped ordering and administering or evaluating and managing together difficult to answer given these tasks are performed by different people in my practice. Perhaps these questions should be separated into 2 separate questions.

Well Woman/Gynecology Comments

Affirming interactions with gender non-conforming individuals=highly 3. Also, supportive interactions with LBGTQIA+ individuals

Again, some of the tasks listed are more 3 for my individual practice and others are things which I do not perform but need to know when it is appropriate to refer for additional care/evaluation.

Assessing breast health

Can initiate and manage medications for treatment of mood disorders. Pessary fitting!

HRT info is so 3!

I am not allowed to perform GYN ultrasounds even though I have the training so I need to refer out. I am getting colpo certified in January.

I do a lot of nutrition and weight loss counseling. I also do a lot of stress relief counseling and well-woman lifestyle changes counseling. Also: substance abuse and ETOH abuse in women, and depression screening and treatment in women.

I have not been able to do some things because they have not come up in practice --- such as removing condylomas. I expect it changes from clinic practice to clinic practice. I mainly work in low income settings, so I see a lot of paps, STI, and for contraception.

I practice in KY. In this state, we are not legally allowed to treat the partner unless the partner is also our patient. We may not prescribe medication for anyone that is not currently being seen in our practice. Kentucky is one of the few, if not the only, state that does not allow to treat partners when our patient tests positive for a Sexually Transmitted Infection.

I think the write for Rx and treat the woman's partner for STI are essentially the same question.

I work a couple of part time jobs- one of them is at Planned Parenthood in the Silicon Valley, CA. I think pregnancy options and talking about pregnancy termination is missing from this long list. I know I work at PP and of course this is why I am saying this...but I don't even recall a board exam question that broached the issue of abortion. It's 3. I see women who are super wealthy and super indigent and they all seek abortion for different reasons. Midwives assist pts with both wanted and unwanted pregnancy, right?

In the State of Virginia we cannot legally prescribe STI treatment for the patient's partner.

Most sexual assualt exams are done in ER, not labor and delivery/triage/office, but the skills are 3 to know.

Nexplanon devices

Our group has FNPs/WHNPs who do most GYN. I have about 1 day per week of postpartum/contraception. Infertility goes to the docs.

Our MD's manage and counsel on Essure, sonohystogram, gyne surgery, ectopic pregnancy and treatment of it. Missing: Assess for and counsel on treatment options for anxiety and depression. Assess for completion of and order or refer for routine well-woman procedures including annual mammogram and colonoscopy. Inquire about genetic and familial diseases that could impact health and inquire and be able to interpret importance of any genetic testing that has been completed (BRCA testing).

Question 24: I answered '1' because emergency contraception was grouped in with the prescribing of other contraceptives. I feel that it is 1 to prescribe EC because it interferes with my conscience.

Referral for medication and aspiration abortion, perform medication and aspiration abortion, provide post-abortion counseling and referrals for emotional support

The populations I work for are not interested in cervical caps, diaphragms, foams and sponge.

Primary Care Comments

diabetes screening and management, follow-up for women who have had GDM and are at higher risk for type 2 DM.

Diabetes screening and treatment plan

I feel that midwives are crucial primary care providers and I want our profession to feel more competent and empowered to do so

While I identify women with substance use disorders, I do not develop a treatment plan for substance use. Instead I refer them to a mental health/substance abuse provider. Perhaps this question should be split up into 2 separate questions.

Wish I had more training/education in suturing things other than the vagina. Feel like core midwifery education regarding long-term MANAGEMENT of mood disorders is lacking.

APPENDIX M. RESPONDENT OPINIONS REGARDING TASKS TO BE ADDED TO FUTURE TASK ANALYSES

Possibly family planning, which, though under the topic of gynecology, might include skills outside the scope of normal well woman care.

Well-woman and/or primary care could have included more questions about caring for menopausal patients.

Again, I think addressing pregnancy termination is important. I felt prepared by my alma mater (university of Illinois at Chicago) but I think just the concept or something needs to be on the exam if nothing else just to normalize it more and remind people that it's a thing women deal with and choose. I also work part time at a 'Lesbian owned sperm bank' in San Francisco where I treat women who are heterosexual and LGBT for fertility..I do IUI in clinic there and rx fertility drugs. I do think LGBT issues are important to broach. In San Francisco I have done many pap smears and some IUIs on men.

Cultural safety

Midwifery Practice Requirements

Fertility

Family planning - I provide LARC but no other GYN care generally

Fertility, trans healthcare

Family planning, Infertility

Lactation

LACTATION

Maybe education?

Leadership, quality improvement, quality assurance, peer review; these are all important for practice as a midwife, even to new midwives. For example, I was asked to lead our facility QA (for OBGYNs and CNMs) after only 3 months of practice.

abortion care

LGBT care

I think teaching others should be an included category such as residents, nursing students, or other midwifery students.

Infertility Care

Midwifery care specific to various populations - teens, refugees, etc.

I think there should be an area dedicated to the type of practice you work in --- the areas are vast from homebirth, to birth center, low risk hospital setting, to low socioeconomic areas, etc.

partner care, community health

sonography

Abortion services

More mental health care! Mood disorders, co-morbidities such as bi-polar and substance abuse. Cannot have enough training in these--I see them EVERY DAY -Antepartum, intrapartum, postpartum care of OBESE woman.

The survey mentioned GYN surgery but not cesarean. I have always considered this as an OB surgery and answered it as such. It is an important part of my practice for continuity of care and patient satisfaction, as well as keeping me valuable to my practice.

My practice is learning more about essential oils, using homeopathy throughout pregnancy, IP and PP and how those integrate into practice. We provide free childbirth classes i.e. breastfeeding, newborn classes, baby wearing and then they pay for child birth prep classes, so importance of easily accessible classes for educating patients. Postpartum importance of seeing patients also the 1st week to support breastfeeding, we do a 2wk and 6wk PP, but having more support with breastfeeding to ensure success. Seeing whether other CNMs are doing earlier visits and having more continuation rates of breastfeeding as a result.

Care for trans men

STD dx and tx for men

TABLES

Table 1. Survey Response			
Survey Response	**N**	**Percent**	**Confidence Interval**
Surveys Sent	1,744	100.00	
Bounce Backs	12	0.69	
Opt Outs	0	0.00	
Surveys Delivered to Participants	1,732	99.31	
Surveys Included in the Analysis	348	19.95	+/- 4.70
All Respondents (Includes Completed & Incomplete Surveys)	440	25.40	+/- 4.04

Table 2. Comparison of Survey Respondent Group to Survey Population & AMCB Population						
	Survey Respondents		**Survey Population**		**AMCB Population**	
Background Data	**N**	**Percent**	**N**	**Percent**	**N**	**Percent**
Credential						
CM	6	1.72	29	1.70	96	0.80
CNM	341	97.99	1715	98.30	11246	99.20
*Missing	1	0.29				
Total	348	100.00	1744	100.00	11342	100.00
Gender						
Female	345	99.10	1708	97.90	8715	76.80
Male	1	0.30	12	0.70	67	0.60
Transgender			0	0	0	0
I choose not to respond	1	0.30	3	0.20	17	0.20
Missing	1	0.30	21	1.20	2543	22.40
Total	348	100.00	1744	100.00	11342	100.00
Race/Ethnicity						
American Indian or Alaska Native	2	0.60	8	0.50	49	0.40
Asian	10	2.90	25	1.40	90	0.80
Black or African American	18	5.20	114	6.50	568	5.00
Hispanic/Latino	10	2.90				
Indian/Pakistani	1	0.30	3	0.20	21	0.20
Native Hawaiian or other Pacific Islander			2	0.10	10	0.10
White or Caucasian	286	82.20	1365	78.30	8105	71.50
I choose not to respond	7	2.00	38	2.20	199	1.80
Other Race (please specify)			39	2.20	162	1.40
(On survey: More than one race)						
More than one race	14	4.00				
Missing		0	150	8.60	2138	18.80
Total	348	100.00	1744	100.00	11342	100.00

Table 2 (Continued) Comparison of Survey Respondent Group to Survey Population & AMCB Population						
	Survey Respondents		Survey Population		AMCB Population	
Background Data	N	Percent	N	Percent	N	Percent
Age Range						
20-25	4	1.15	28	1.60	30	0.30
26-30	88	25.29	465	26.70	609	5.40
31-35	106	30.46	502	28.80	1,267	11.20
36-40	63	18.10	335	19.20	1,396	12.30
41-45	49	14.08	224	12.80	1,336	11.80
46+	36	10.34	183	10.50	5,415	47.70
Missing	2	0.60	7	0.40	1,289	11.40
Total	348	100.00	1,744	100.00	11,342	100.10
Mean	35.7		35.7		47.9	
Median	34		34		47	
Mode	29		29		39	

Table 3. My gender is:		
Responses	**Frequency**	**Percent**
Female	345	99.1
Male	1	0.3
Decline to answer	1	0.3
Missing	1	0.3
Total	348	100

Table 4. My race/ethnicity is:		
Responses	**Frequency**	**Percent**
American Indian or Alaska Native	2	0.6
Asian	10	2.9
Black or African American	18	5.2
Hispanic or Latino	10	2.9
Indian/Pakistani	1	0.3
White or Caucasian	286	82.2
More than one race	14	4
Decline to answer	7	2
Total	348	100

Table 5. My Age			
Age	**Frequency**	**Percent**	**Cumulative Percent**
24	2	0.6	0.6
25	2	0.6	1.2
26	13	3.7	4.9
27	11	3.2	8.1
28	21	6	14.2
29	29	8.3	22.5
30	14	4	26.6
31	20	5.7	32.4
32	21	6	38.4
33	20	5.7	44.2
34	21	6	50.3
35	24	6.9	57.2
36	11	3.2	60.4
37	21	6	66.5
38	11	3.2	69.7
39	13	3.7	73.4
40	7	2	75.4
41	15	4.3	79.8
42	17	4.9	84.7
43	5	1.4	86.1
44	2	0.6	86.7
45	10	2.9	89.6
46	4	1.1	90.8
47	6	1.7	92.5
48	7	2	94.5
50	5	1.4	96
51	1	0.3	96.2
52	1	0.3	96.5
53	1	0.3	96.8
54	2	0.6	97.4
55	2	0.6	98
56	1	0.3	98.3
57	4	1.1	99.4
58	1	0.3	99.7
59	1	0.3	100
Total	346	99.4	
Missing	2	0.6	
Total	348	100	

Table 6. The highest degree I have earned is a(n):		
Response	**Frequency**	**Percent**
DNP Degree	23	6.6
Master's Degree	315	90.5
PhD Degree	2	0.6
Other	5	1.4
Missing	3	0.9
Total	348	100

Table 7. Other [specify] The highest degree I have earned is a(n):		
Response	**Frequency**	**Percent**
Doctorate in Naturopathic Medicine (ND)	1	0.3
PMC	1	0.3
Post-Master's	1	0.3
Post Master's	1	0.3
Post Master's degree	1	0.3
Did not select this option	343	98.6
Total	348	100

Table 8. I was employed as an RN before certification:		
Response	**Frequency**	**Percent**
No	60	17.2
Yes	286	82.2
Missing	2	0.6
Total	348	100

Table 9. Before certification, I worked as an RN for: (Number of Years)	
Mean	8.57
SD	6.14
Median	7
Mode	5

Table 10. Are you currently working as a midwife?		
Response	**Frequency**	**Percent**
Yes	348	100

Table 11. My current employment status in midwifery is:		
Response	**Frequency**	**Percent**
Full-time	313	89.9
Part-time	23	6.6
Per Diem	9	2.6
Missing	3	0.9
Total	348	100

Table 12. In which U.S. state or location is your primary practice?		
State/Location	**Frequency**	**Percent**
AK	8	2.3
AZ	6	1.7
CA	20	5.7
CO	8	2.3
CT	3	0.9
DC	3	0.9
DE	2	0.6
FL	16	4.6
GA	14	4
IA	4	1.1
ID	2	0.6
IL	24	6.9
IN	9	2.6
KS	4	1.1
KY	5	1.4
LA	3	0.9
MA	7	2
MD	8	2.3
MI	18	5.2
MN	6	1.7
MO	1	0.3
MS	2	0.6
MT	3	0.9
NC	14	4
NE	1	0.3
NH	2	0.6
NJ	8	2.3
NM	6	1.7
NV	1	0.3
NY	29	8.3
OH	8	2.3

Table 12 (Continued) In which U.S. state or location is your primary practice?		
State/Location	**Frequency**	**Percent**
OK	5	1.4
OR	9	2.6
PA	13	3.7
RI	1	0.3
SC	3	0.9
SD	4	1.1
TN	3	0.9
TX	15	4.3
UT	5	1.4
VA	13	3.7
VT	3	0.9
WA	15	4.3
WI	8	2.3
WV	2	0.6
WY	1	0.3
Other - overseas, Licensed in US	1	0.3
Decline to answer	1	0.3
Missing	1	0.3
Total	348	100

Table 13. In addition to your primary U.S. state or location, do you practice in any additional U.S. states or locations? Not including volunteer work.		
Response	**Frequency**	**Percent**
No	328	94.3
Yes	14	4
Missing	6	1.7
Total	348	100

Table 14. In addition to your primary U.S. state or location, please indicate any additional U.S. states or locations in which you practice. Do not include volunteer work. Check all that apply.		
State/Location	**Frequency**	**Percent**
AK	1	0.003
DC	1	0.003
LA	1	0.003
MA	1	0.003
MI	2	0.006
MO	1	0.003
MT	2	0.006
NC	1	0.003
NM	1	0.003
NY	1	0.003
Decline to answer	1	0.003
Total	13	0.037
Skipped this question	335	0.963
Total	348	1

Table 15. I practice midwifery in an area that is primarily:		
Response	**Frequency**	**Percent**
Rural	25	7.2
Town (population less than 10,000)	20	5.7
City (population 10,001-50,000)	59	17
City (population 100,001-250,000)	49	14.1
City (population 50,001-100,000)	67	19.3
City (population over 250,000)	123	35.3
Decline to answer	4	1.1
Missing	1	0.3
Total	348	100

Table 16. Certifications		
Response	**Frequency**	**Percent**
CM only	6	1.72
CNM only	338	97.13
CPM only	0	0.00
CNM & CPM	3	0.86
Missing	1	0.29
Total	348	100

Table 17. I am also certified as:		
Response	**N**	**Percent**
Midwife Only	223	66.97
Family Nurse Practitioner (FNP)	21	6.31
Women's Health Care Nurse Practitioner (WHCNP)	66	19.82
Adult Nurse Practitioner (ANP)	1	0.30
Neonatal Nurse Practitioner (NNP)	0	0.00
Psych-Mental Health Nurse Practitioner	0	0.00
Registered Diagnostic Medical Sonographer	0	0.00
IBCLC	12	3.60
SANE	3	0.90
Other	7	2.10
Total	333	100

Table 18. Other (please specify) I am also certified as:
1. C-EFM
2. Certified Childbirth Educator
3. House manager
4. Lamaze Certified Childbirth Educator
5. Naturopathic Physician
6. Ob/Gyn NP

Table 19. I have prescriptive authority:		
Response	**Frequency**	**Percent**
No	8	2.3
Pending	13	3.7
Yes	327	94
Total	348	100

Table 20. My PRIMARY midwifery employer is a (n):		
Response	**Frequency**	**Percent**
(Nurse) Midwifery Group	43	12.4
Community Health Center	34	9.8
Educational Institution	4	1.1
Federal Government/Military	15	4.3
Hospital/Medical Center	107	30.7
Physician Group	96	27.6
Self-employed/solo practice	13	3.7
State/Local Government	7	2
Other	14	4
Missing	15	4.3
Total	348	100

Table 21. Other [specify]: My PRIMARY midwifery employer is a (n):		
Response	**Frequency**	**Percent**
1. Birth center company	1	0.3
2. CNM/MD group practice	1	0.3
3. Collaborative CPM/CNM birth center	1	0.3
4. Free-standing birth center (B&C)	1	0.3
5. free standing birth center, non-profit	1	0.3
6. Homebirth Practice	1	0.3
7. Kaiser Permanente	1	0.3
8. Midwife owned birth center	1	0.3
9. One MD, two CNMs, privately owned	1	0.3
10. Planned parenthood	1	0.3
11. Tribal (638) hospital/clinic	1	0.3
12. Tribal Facility	1	0.3
13. Tribally owned clinic	1	0.3
Did not select this option.	335	96.3
Total	348	100

Table 22. I have hospital privileges:		
Response	**Frequency**	**Percent**
No	45	12.9
Pending	26	7.5
Yes	275	79
Missing	2	0.6
Total	348	100

Table 23. I have hospital staff membership through:		
Response	**Frequency**	**Percent**
Allied Health staff	55	15.8
Medical staff	158	45.4
I do not know	58	16.7
None	3	0.9
Missing	74	21.3
Total	348	100

Table 24. Approximately how many minutes did it take you to complete the survey?	
Mean	39.37
SD	17.85
Range	140
N	58
Blank	290

Table 25. Were the directions in the survey clear?		
Response	**N**	**Percent**
Yes	289	83.05
No	2	0.57
Blank	57	16.38
Total	348	100.00

Table 26. Were the directions in the survey clear? Please indicate your reason for selecting 'No' to the previous question.	
1.	It would help if the options from never to always were repeated throughout the listing the respondent doesn't have to scroll back up to see which circle is which option
2.	Perhaps using a percentage portion would be better to describe how often I treat patients for certain conditions or perform certain tasks in clinic. I often counsel women on fetal movement after 30 weeks of gestation but don't feel like monthly or weekly quite reflect the amount that I perform this task.

Table 27. Participant Opinions Regarding Current Requirements for Eligibility for Certification and Recertification Requirements								
	Yes		No		Blank		Total	
Question	N	Percent	N	Percent	N	Percent	N	Percent
1. In your opinion, are the current eligibility requirements (listed above) for candidates from Nurse-Midwifery Educational Programs to take the AMCB examination necessary to achieve competence as a midwife?	286	82.18	7	2.01	55	15.80	348	100.00
2. In your opinion, are the current eligibility requirements (listed above) for Candidates from Midwifery Education Programs to take the AMCB examination necessary to achieve competence as a midwife?	284	81.61	5	1.44	59	16.95	348	100.00
3. In your opinion, after the certification is obtained, are the recertification requirements (listed above) appropriate to maintain competence as a midwife?	281	80.75	11	3.16	56	16.09	348	100.00

Table 28. In your opinion, are the current eligibility requirements (listed above) for candidates from Nurse-Midwifery Educational Programs to take the AMCB examination necessary to achieve competence as a midwife? Please indicate your reason for selecting 'No' to the previous question.	
1.	Clear expectations are not laid out for seeing and identifying all types of GYN issues. A new CNM may have met the GYN visit requirement but if they only did annual exams they are missing a big piece of GYN care that requires a diagnostic work-up for abnormalities. I think it would be wise that future candidates be required to see specific types of GYN cases, including menopausal management, specific vulvar dermatology issues, vulvar biopsy and management of vulvar dermatology. As a new grad I felt very lacking in these area at the beginning of my practice and I had the benefit of having many more GYN cases than many of my classmates so I can only imagine how they struggled in the beginning.
2.	I believe Verification OR Attestation by the director of a Nurse-midwifery program should be sufficient and not necessary for BOTH. This is a time consuming effort and often causes lag in the candidates ability to become certified in a timely manner. Getting a transcript that shows completion of a program in a satisfactory account could also be sufficient to prove completion.
3.	I don't think RN licensure is needed to achieve competence as a midwife.
4.	I think that 2 years of prior nursing experience, NOT L&D experience, any nursing experience, should be required before being able to start a CNM program. If not, CNMs get out of school not competent work in a full scope practice.
5.	I think this is an appropriate set of criteria for preparation as a nurse-midwife in the United States. However, I think there are several other valid means to achieve competence as a midwife, including non-nurse midwifery programs and preparation in other countries' educational systems.
6.	I, and many of my colleagues, did not practice as nurses before becoming midwives. As such, I am unsure if the nursing component is essential to future CNMs. In many ways, nursing and midwifery are separate roles, especially when practicing in a hospital setting.
7.	Verification by program director of program completion and date is not necessary

Table 29. In your opinion, are the current eligibility requirements (listed above) for Candidates from Midwifery Education Programs to take the AMCB examination necessary to achieve competence as a midwife? Please indicate your reason for selecting 'No' to the previous question.	
1.	Again either verification or attestation of level of safe care as a beginning practitioner should be sufficient.
2.	As I indicated in the previous question, I think this is a valid preparatory path, but not the only valid path - i.e., this could be considered *sufficient* but not *necessary* (e.g. one could achieve competence as a midwife through education in another country's educational system, such as the U.K.).
3.	I believe all midwives should have to be CNMs
4.	I think they should be knowledgable in all medical practice such as with a pm RN degree first.
5.	Soap Box: i don't know how I feel about there being several different points of entry into the midwifery profession...I suppose it's beneficial for Women to have as many midwives in practice as possible. I also feel that it undermines my Nursing degrees and the entire career I've worked for. Furthermore, I think it devalues the profession a bit when there are several ways to get a midwifery education.

Table 30. In your opinion, after the certification is obtained, are the recertification requirements (listed above) appropriate to maintain competence as a midwife? Please indicate your reason for selecting 'No' to the previous question.	
1.	Because I know many CNMs who share answers and will not read the continuing ed themselves. I do not feel that the recertification process is strict enough.
2.	Because most states require same or more and the CMM modules can be replaced by standard CME ac1uired through conferences etc.
3.	CMM are not necessary, only CEU
4.	I believe the Certificate Maintenance Modules should award contact hours, if only 1-2 hours but at least some contact hours for the work.
5.	I don't think Nurse Midwives should require the same amt of maintenance modules as CM. We also have to complete licensure and CEU requirements at the state level, which can be extensive based on the state.
6.	Instead of the module system, I think that the CEU's should be increased so that knowledge can be obtained in various areas that pertain to a particular area of practice that the CNM is interested in.
7.	It is difficult to complete all the components of Option 1 while working. Either part 1 or part 2 of Option 1 seems more reasonable.
8.	The credits from the certificate maintenance modules should count.
9.	The maintenance modules are excessive for those of practicing.
10.	While the modules are appropriate, it is inappropriate to require the modules to be done without providing the articles needed. It is very hard and cost prohibitive for many midwives to access the articles when they are so expensive and we no longer have access to article databases. The articles should be provided as part of the fees we already have to pay, which are high as it is, especially for those who are not working full time.

Table 31. ANTEPARTUM TASKS										
	Frequency				Importance				Unweighted Composite Score	Recommended for Consideration for Elimination by AMCB BOD
Task Statements	N	M	SD	Range	N	M	SD	Range		
1. Evaluates the woman for presumptive signs of pregnancy.	324	4.57	0.99	4	317	3.39	0.77	3	7.96	
2. Screens the woman during pregnancy for violence or abuse.	325	4.79	0.64	4	317	3.85	0.39	2	8.64	
3. Orders/obtains/interprets laboratory tests to determine baseline values and deviations from normal.	324	4.98	0.19	2	317	3.96	0.19	1	8.94	
4. Assesses the woman's acceptance of pregnancy.	324	4.84	0.59	4	317	3.71	0.51	3	8.55	
5. Supports woman for mothering role development.	322	4.84	0.53	4	314	3.67	0.56	3	8.51	
6. Evaluates bony pelvis and determines pelvic type.	325	3.86	1.54	4	315	2.46	1.04	3	6.32	
7. Refers the woman and her family to community resources as indicated (e.g., WIC, nutrition, social services).	325	4.57	0.8	4	316	3.68	0.57	3	8.25	
8. Promotes the involvement of parents and families in preparation for childbearing, such as fetal development and options for informed childbirth.	324	4.84	0.47	4	314	3.71	0.53	2	8.55	
9. Identifies deviations from normal pregnancy; develops a management plan to respond to deviations; consults and/or refers as necessary.	323	4.94	0.25	2	312	3.97	0.18	1	8.91	
10. Performs sonography independently to establish or confirm gestational age.	325	1.97	1.62	4	313	2.36	1.17	3	4.33	
11. Orders sonography independently to establish or confirm gestational age.	324	4.61	0.91	4	316	3.62	0.68	3	8.23	
12. Performs sonogram to rule out fetal abnormality.	**324**	**1.17**	0.75	**4**	**313**	2	1.17	**3**	3.17	**X**
13. Refers for sonogram to rule out fetal abnormality.	325	4.56	0.94	4	314	3.74	0.58	3	8.3	
14. Orders biophysical profile.	325	4.36	0.93	4	316	3.73	0.54	3	8.09	
15. Performs biophysical profile.	**325**	**1.27**	0.87	**4**	**314**	2.18	1.17	**3**	3.44	**X**

Table 31 (Continued): ANTEPARTUM TASKS										
	Frequency				Importance				Unweighted Composite Score	Recommended for Consideration for Elimination by AMCB BOD
Task Statements	N	M	SD	Range	N	M	SD	Range		
16. Interprets biophysical profile results.	323	3.76	1.55	4	313	3.65	0.73	3	7.41	
17. Performs sonography for amniotic fluid volume, presentation, and/or placental location.	324	2.29	1.73	4	313	2.63	1.23	3	4.92	
18. Evaluates historical, physical and laboratory data to determine current gestational age and EDC.	325	4.87	0.56	4	315	3.89	0.37	3	8.75	
19. Provides counseling regarding pregnancy options, including termination.	325	4.11	1.26	4	316	3.68	0.64	3	7.79	
20. Questions woman about fetal movement and instructs her in fetal movement monitoring.	324	4.96	0.23	2	315	3.87	0.35	2	8.83	
21. Measures abdomen by centimeter tape and/or fingerbreadth to assess fundal height and fetal growth.	324	4.94	0.37	4	316	3.81	0.45	3	8.75	
22. Orders and interprets nonstress tests.	325	4.72	0.79	4	316	3.86	0.4	3	8.59	
23. Prepares the woman and her family for expected/anticipated mode of birth with guidance to the appropriate setting.	324	4.88	0.48	4	315	3.71	0.56	3	8.6	
24. Questions and counsels woman regarding possible teratogen exposure (medications, recreational drugs, smoking, alcohol, caffeine, household pets, toxic chemicals, or radiation).	324	4.83	0.48	4	316	3.78	0.49	3	8.61	
25. Determines menstrual history and date of LNMP.	325	4.87	0.53	4	314	3.81	0.43	3	8.69	
26. Determines presence and level of hCG in the serum or urine.	325	4.5	0.93	4	315	3.55	0.69	3	8.05	
27. Identifies the need for genetic counseling and provides or makes referral.	325	4.65	0.77	4	316	3.68	0.53	3	8.33	

Table 31 (Continued): ANTEPARTUM TASKS										
	Frequency				Importance					
Task Statements	N	M	SD	Range	N	M	SD	Range	Unweighted Composite Score	Recommended for Consideration for Elimination by AMCB BOD
28. Evaluates current nutritional status by obtaining a diet history, pre-pregnant weight and interval pregnancy weight gain patterns.	325	4.78	0.62	4	316	3.68	0.52	3	8.47	
29. Determines BMI.	325	4.8	0.67	4	316	3.4	0.76	3	8.2	
30. Counsels woman and family about normal physiology of pregnancy, common discomforts, and self-care during pregnancy.	324	4.96	0.22	2	313	3.88	0.36	2	8.84	
31. Orders/obtains/interprets laboratory work during the pregnancy.	325	4.96	0.24	2	315	3.92	0.27	1	8.88	
32. Performs Leopold's maneuvers on abdomen to determine presentation, lie, position of fetus, and estimated weight of fetus.	321	4.95	0.31	4	315	3.86	0.34	1	8.81	
33. Prepares the woman and her family for pain management in labor and discusses options.	322	4.9	0.39	4	314	3.83	0.39	2	8.74	
34. Determines appropriateness of vaginal birth after cesarean (VBAC) and counsels for risk/benefit.	324	3.95	1.46	4	316	3.72	0.61	3	7.67	
35. Evaluates serial hCG levels.	324	4.19	1	4	315	3.55	0.7	3	7.74	
36. Evaluates for and manages woman with A1 diabetes in pregnancy (i.e., diet, exercise, glucose monitoring).	324	4.02	1.37	4	315	3.64	0.68	3	7.66	
37. Evaluates for and manages woman with A2 diabetes in pregnancy (pharmaceuticals, diet, exercise, glucose monitoring, fetal surveillance).	324	3.1	1.67	4	312	3.32	0.89	3	6.43	

Table 31 (Continued): ANTEPARTUM TASKS										
	Frequency				Importance					
Task Statements	N	M	SD	Range	N	M	SD	Range	Unweighted Composite Score	Recommended for Consideration for Elimination by AMCB BOD
38. Counsels woman about alternate and complementary therapies, such as use of herbs (e.g., evening primrose oil, red raspberry, ginger), acupressure, and biofeedback.	323	4.31	1.05	4	315	3.19	0.8	3	7.5	
39. Provide group or Centering Pregnancy (TM) care.	323	1.56	1.31	4	314	2.6	1.06	3	4.16	
40. Counsels for substance abuse.	323	3.84	1.33	4	315	3.59	0.66	3	7.43	
41. Interprets labs for pregnancy-induced hypertension.	324	4.5	0.75	4	313	3.91	0.32	2	8.4	
42. Cares for the patient with hypertensive disorders in pregnancy.	324	4.03	1.23	4	312	3.58	0.7	3	7.61	
43. Counsels where spontaneous abortion or intrauterine fetal demise has occurred.	322	3.96	1.03	4	314	3.8	0.49	3	7.76	
44. Provide counseling for best birth setting (i.e., home, birth center, hospital).	324	3.26	1.71	4	315	3.34	0.87	3	6.59	
45. Orders Rh immunoglobulin when indicated during pregnancy.	324	4.66	0.61	3	312	3.89	0.32	2	8.55	

Table 32. INTRAPARTUM TASKS										
	Frequency				Importance				Unweighted Composite Score	Recommended for Consideration for Elimination by AMCB BOD
Task Statements	N	M	SD	Range	N	M	SD	Range		
46. Determines fetal presentation.	297	4.96	0.24	2	274	3.96	0.22	2	8.91	
47. Initiates a plan to meet the nutritional needs of the laboring woman.	296	4.73	0.76	4	275	3.59	0.65	3	8.32	
48. Monitors labor pattern through palpation to observe the strength, duration, and frequency of contractions.	293	4.78	0.62	4	275	3.76	0.56	3	8.53	
49. Performs artificial rupture of membranes (AROM).	297	4.51	0.73	4	275	3.55	0.7	3	8.06	
50. Places intrauterine pressure catheter (IUPC) for monitoring uterine contractions.	295	3.77	1.24	4	272	3.4	0.87	3	7.17	
51. Develops a plan for decreasing discomfort in labor (e.g., orders analgesics, hot/cold application, showers/baths).	296	4.92	0.33	3	273	3.88	0.34	2	8.79	
52. Initiates a plan of care for managing deviations from the normal progress of labor.	296	4.83	0.45	3	271	3.92	0.27	1	8.75	
53. Administers pudendal anesthesia.	**295**	**1.2**	**0.74**	**4**	**272**	**1.99**	**1.11**	**3**	**3.19**	**X**
54. Delivers infant in mother's choice of appropriate supportive modalities, such as birthing stool or water birth.	294	3.95	1.48	4	275	3.63	0.75	3	7.58	
55. Delivers infant in the occiput posterior position (OP).	294	3.82	1.04	4	274	3.75	0.48	2	7.57	
56. Manages nuchal cord.	295	4.62	0.65	4	274	3.93	0.27	2	8.55	
57. Initiates active management of the third stage of labor.	294	4.54	0.93	4	274	3.69	0.62	3	8.23	
58. Delivers placenta and membranes by means of maternal effort and/or gentle manual traction.	294	4.86	0.46	4	270	3.86	0.39	2	8.72	
59. Repairs episiotomy and/or 1st or 2nd degree lacerations of the perineum.	293	4.73	0.6	3	273	3.95	0.23	1	8.68	
60. Repairs 3rd degree lacerations.	**294**	**1.3**	**0.87**	**4**	**272**	**2.18**	**1.13**	**3**	**3.48**	**X**
61. Repairs 4th degree lacerations.	**292**	**1**	**0.06**	**1**	**271**	**1.87**	**1.08**	**3**	**2.87**	**X**

62. Repairs lacerations of the cervix.	**294**	**1.08**	**0.43**	**4**	**270**	**2**	**1.1**	3	**3.08**	**X**

Table 32. (Continued) INTRAPARTUM TASKS

Task Statements	Frequency				Importance				Unweighted Composite Score	Recommended for Consideration for Elimination by AMCB BOD
	N	M	SD	Range	N	M	SD	Range		
63. Inspects placenta and membranes to ascertain their completeness, to rule out retained fragments, and to check for abnormalities.	292	4.91	0.34	3	274	3.93	0.27	2	8.85	
64. Performs manual exploration of the uterus.	293	2.89	1.27	4	273	3.43	0.8	3	6.32	
65. Evaluates woman for onset of labor.	291	4.9	0.41	4	274	3.91	0.3	2	8.81	
66. Determines status of amniotic membranes by woman's report, observation for pooling of fluid, use of nitrazine paper, and/or exam of fluid for ferning.	291	4.76	0.57	4	272	3.94	0.24	1	8.7	
67. Orders/administers cervical ripening agents (e.g., Foley bulb, misoprostol, and PGE2 agents).	293	4.41	1.03	4	274	3.72	0.66	3	8.13	
68. Evaluates fetal condition following rupture of membranes to determine fetal well-being.	288	4.88	0.4	3	274	3.93	0.25	1	8.81	
69. Orders and manages amnioinfusion.	292	3.15	1.35	4	273	3.25	0.93	3	6.4	
70. Provides emotional support to the woman and her family.	293	4.93	0.32	3	271	3.94	0.24	1	8.87	
71. Manages or co-manages care of the woman with an epidural.	293	4.59	1.1	4	272	3.76	0.69	3	8.34	
72. Administers local anesthesia.	293	4.44	1.04	4	271	3.73	0.66	3	8.17	
73. Delivers infant with mother in various positions, such as side-lying, knee-chest, or squatting.	293	4.69	0.67	4	272	3.88	0.36	2	8.56	
74. Delivers baby in breech position.	295	1.1	0.47	4	272	2.42	1.18	3	3.52	
75. Delivers baby in face presentation.	294	1.27	0.61	4	271	2.55	1.14	3	3.81	
76. Delivers baby with vacuum.	295	1.05	0.34	4	271	2.02	1.13	3	3.07	
77. Delivers baby with forceps.	**294**	**1.01**	**0.23**	**4**	**272**	**1.75**	**1.08**	**3**	**2.76**	**X**
78. First Assists with Cesarean birth.	293	2.57	1.68	4	273	2.69		3	5.26	

Table 32. (Continued) INTRAPARTUM TASKS										
	Frequency				Importance				Unweighted Composite Score	Recommended for Consideration for Elimination by AMCB BOD
Task Statements	N	M	SD	Range	N	M	SD	Range		
79. Delays cord clamping until pulsations have ceased unless earlier severance is medically indicated (e.g., tight nuchal cord, need for resuscitation).	294	4.84	0.52	4	274	3.8	0.46	2	8.64	
80. Evaluates rectal integrity following delivery with episiotomy or extensive lacerations.	294	3.83	1.22	4	274	3.72	0.57	3	7.55	
81. Controls hemorrhage, by pharmaceutical administration, fundal massage, bimanual compression, initiation of breastfeeding and/or vaginal/cervical laceration repair.	295	4.37	0.87	4	273	3.97	0.18	1	8.33	
82. Performs bimanual compression.	294	3.14	1.18	4	274	3.88	0.37	2	7.02	
83. Evaluates etiology of postpartum hemorrhage, including uterine atony and vaginal/cervical lacerations.	295	4.14	0.95	4	272	3.95	0.25	2	8.09	
84. Orders blood transfusion where clinically indicated for severe postpartum hemorrhage.	294	2.49	1.34	4	273	3.48	0.89	3	5.97	
85. Estimates gestational age and fetal weight incorporating all available data.	295	4.47	1.12	4	274	3.58	0.7	3	8.05	
86. Determines position of presenting part by abdominal and vaginal exam.	294	4.89	0.43	4	273	3.92	0.29	2	8.81	
87. Evaluates physical response to process of labor.	294	4.91	0.34	3	272	3.89	0.33	2	8.8	
88. Monitors fetal well-being and response to contractions through the application of external electronic fetal monitor tracing.	293	4.63	1.06	4	273	3.76	0.66	3	8.39	
89. Monitors progress of labor by vaginal determination of cervical position, effacement and dilation, descent of presenting part, and position of presenting part.	291	4.91	0.35	3	274	3.92	0.34	2	8.83	

Table 32. (Continued) INTRAPARTUM TASKS										
	Frequency				Importance				Unweighted Composite Score	Recommended for Consideration for Elimination by AMCB BOD
Task Statements	N	M	SD	Range	N	M	SD	Range		
90. Applies internal fetal scalp electrode.	295	3.6	1.28	4	273	3.51	0.81	3	7.11	
91. Informs woman about and initiates use of complementary analgesic therapies, such as TENS, sterile water papules, or hydrotherapy.	294	3.71	1.54	4	273	3.42	0.83	3	7.13	
92. Evaluates response to and monitors for side effects of medications used to treat problems, such as magnesium sulfate or tocolytics.	294	3.43	1.44	4	272	3.51	0.86	3	6.94	
93. Promotes effective second stage of labor progress (e.g., verbal encouragement, use of alternative positions to facilitate delivery).	294	4.88	0.37	3	273	3.89	0.33	2	8.78	
94. Performs episiotomies when indicated.	295	2.61	1.18	4	274	3.57	0.69	3	6.18	
95. Initiates maneuvers to resolve shoulder dystocia.	294	3.2	1.05	4	272	3.97	0.19	2	7.17	
96. Determines separation of placenta.	294	4.81	0.59	4	273	3.87	0.35	2	8.68	
97. Estimates blood loss.	291	4.89	0.4	3	273	3.84	0.39	2	8.73	
98. Examines cervix, vagina and perineum for lacerations and/or episiotomy extensions and identifies need for repair.	293	4.89	0.36	3	272	3.94	0.24	1	8.83	
99. Sends placenta to pathology.	293	3.23	1.18	4	273	3.2	0.89	3	6.43	
100. Orders pitocin for augmentation of labor.	294	4.18	1.17	4	271	3.61	0.74	3	7.8	
101. Evaluates for chorioamnionitis.	294	4.27	0.94	4	273	3.84	0.39	2	8.1	
102. Manages chorioamnionitis.	293	3.34	1.27	4	272	3.59	0.72	3	6.93	
103. Manages spontaneous labor for woman with a prior Cesarean birth.	293	3.42	1.5	4	271	3.68	0.72	3	7.1	
104. Initiates labor induction for women electing vaginal birth after Cesarean (VBAC).	293	2.45	1.53	4	270	3.17	1.11	3	5.62	
105. Manages care of the woman having a waterbirth.	292	2.07	1.58	4	273	3.08	1.12	3	5.15	
106. Delivers infant when demise has occurred.	294	2.13	1.16	4	272	3.42	0.91	3	5.54	

Table 33. POSTPARTUM TASKS										
	Frequency				Importance					
Task Statements	N	M	SD	Range	N	M	SD	Range	Unweighted Composite Score	Recommended for Consideration for Elimination by AMCB BOD
107. Provides information about breast anatomy and physiology, maintenance of milk supply, and care of lactation problems (e.g., sore nipples, engorgement, mastitis).	282	4.74	0.59	4	277	3.87	0.37	2	8.61	
108. Refers for lactation consultation as indicated.	281	4.54	0.89	4	277	3.83	0.41	2	8.38	
109. Performs postpartum physical exam.	281	4.87	0.46	4	275	3.92	0.27	1	8.79	
110. Screens the woman during the postpartum period for symptoms of depression with a standardized psychological instrument.	281	4.69	0.86	4	273	3.95	0.22	1	8.64	
111. Evaluates and manages vaginal, perineal or rectal hematomas.	281	3.21	1.45	4	276	3.44	0.8	3	6.65	
112. Manage postpartum/procedural pain relief.	281	4.57	0.92	4	277	3.75	0.51	3	8.32	
113. Assesses for postanesthesia complications or side effects, such as hypotension and spinal headache, and manages, consults, or refers.	281	3.56	1.51	4	275	3.48	0.84	3	7.04	
114. Orders maternal immunizations in the immediate postpartum.	282	4.2	1.31	4	276	3.58	0.73	3	7.77	
115. Discusses with woman/family plans for continued health care for mother and well-baby care for infant.	281	4.85	0.49	4	276	3.83	0.41	2	8.68	
116. Evaluates for postpartum abnormalities (e.g., anemia, DVE, UTI, endometritis).	281	4.65	0.76	4	276	3.9	0.31	2	8.55	
117. Evaluates and manages post-Cesarean care.	282	3.59	1.57	4	277	3.32	0.94	3	6.91	
118. Assesses and manages postpartum hemorrhoids, including pharmaceuticals.	282	4.44	0.87	4	274	3.64	0.58	2	8.09	
119. Lance external thrombosed hemorrhoids.	**280**	**1.28**	**0.88**	**4**	**275**	**2.07**	**1.17**	**3**	**3.34**	**X**

120. Screens for symptoms of anxiety.	281	4.68	0.73	4	277	3.86	0.37	2	8.54	
121. Provides lactation support.	281	4.62	0.78	4	275	3.85	0.4	2	8.47	

Table 34. NEWBORN TASKS

	Frequency				Importance					
Task Statements	**N**	**M**	**SD**	**Range**	**N**	**M**	**SD**	**Range**	**Unweighted Composite Score**	**Recommended for Consideration for Elimination by AMCB BOD**
122. Promotes adequate respirations by appropriately stimulating the newborn when needed (e.g., suction catheter, oxygen administration, back/foot massage).	65	4.45	1.02	4	63	3.98	0.12	1	8.43	
123. Supports newborn thermoregulation.	65	4.74	0.73	4	64	3.98	0.12	1	8.72	
124. Evaluates well-being of the newborn at one and five minutes by means of Apgar scoring.	65	4.22	1.41	4	57	3.65	0.74	3	7.86	
125. Initiates chemoprophylaxis in preventing opthalmic neonatorum.	65	3.18	1.71	4	45	2.83	1.02	3	6.01	
126. Provides education about newborn feeding.	64	4.77	0.64	3	64	3.86	0.39	2	8.63	
127. Observes and, if necessary, clears infant's breathing passages by bulb suction, suction catheter, and encouraging sucking behavior	64	4.53	0.91	4	63	3.91	0.42	3	8.44	
128. Maintains infant's temperature by drying and covering infant, keeping infant in close proximity to mother, or use of warming beds.	65	4.65	0.94	4	63	3.97	0.17	1	8.62	
129. Examines cord for umbilical vessels.	65	4.75	0.75	4	64	3.74	0.54	3	8.49	
130. Orders and/or administers Vitamin K.	65	4.22	1.43	4	56	3.48	0.87	3	7.7	
131. Educates woman about breastfeeding and assists her in the technique.	65	4.69	0.77	3	65	3.94	0.3	2	8.63	
132. Educates woman about formula feeding, if chosen.	65	3.28	1.42	4	59	3.42	0.79	3	6.69	
133. Performs complete newborn physical exam.	65	4.05	1.58	4	53	3.58	0.9	3	7.63	
134. Evaluates and manages infants with problems such as jaundice, lethargy, feeding difficulty or temperature instability.	65	3.15	1.63	4	45	3.37	1.02	3	6.52	

135. Obtains or arranges for blood specimens from infant for laboratory tests required by law such as PKU, galactosemia, and thyroid functions.	65	3.2	1.83	4	41	3.18	1.1	3	6.38	

Table 34. (Continued) NEWBORN TASKS

Task Statements	Frequency				Importance				Unweighted Composite Score	Recommended for Consideration for Elimination by AMCB BOD
	N	M	SD	Range	N	M	SD	Range		
136. Orders immunizations during the neonatal period.	65	1.86	1.54	4	17	2.48	1.15	3	4.35	
137. Creates an environment for healthy maternal-infant interaction.	64	4.83	0.58	3	64	3.88	0.33	1	8.71	
138. Provides guidance concerning newborn care (e.g., cord care, temperature maintenance, feeding patterns, skin hygiene, infant behavior) to provide for the baby's well-being.	64	4.42	1.05	4	61	3.81	0.61	3	8.23	
139. Orders and interprets bilirubin levels.	65	2.23	1.5	4	30	2.92	1.16	3	5.15	
140. Manages well-baby visits past 1 week of age.	65	2.29	1.77	4	24	2.55	1.26	3	4.84	
141. Evaluates infant for transition to extrauterine life and manages or refers as indicated.	65	4.4	1.28	4	59	3.8	0.62	3	8.2	
142. Resuscitates infant by use of positive pressure breathing bag, CPR, and notifies appropriate collaborating personnel (e.g., physician or NICU or transport team).	65	2.63	1.18	4	55	3.92	0.41	3	6.55	
143. Performs infant intubation with laryngoscope.	65	1.23	0.61	4	12	2.74	1.24	3	3.97	
144. Collects cord blood.	65	4.11	1.35	4	59	3.56	0.77	3	7.67	
145. Obtains cord gases when necessary.	64	2.36	1.56	4	36		1.01	3	5.56	
146. Performs gestational age examination.	65	3.63	1.71	4	49	3.22	0.9	3	6.85	
147. Recognizes minor malformations that could be associated with major malformations and refers appropriately.	65	3.32	1.43	4	59	3.72	0.6	3	7.04	
148. Provides guidance and counseling regarding male circumcision, acknowledging	65	4.2	1.06	4	63	3.62	0.68	3	7.82	

cultural, religious and familial beliefs.										

Table 34. (Continued) NEWBORN TASKS										
	Frequency				Importance					
Task Statements	N	M	SD	Range	N	M	SD	Range	Unweighted Composite Score	Recommended for Consideration for Elimination by AMCB BOD
149. Performs male infant circumcision.	**65**	**1.31**	**1.03**	**4**	**6**	**1.9**	**1.17**	**3**	3.21	**X**
150. Manages infant who requires phototherapy.	65	1.46	0.99	4	16	2.25	1.23	3	3.71	
151. Orders and/or performs newborn auditory screening.	64	2.56	1.85	4	28	2.53	1.18	3	5.09	

Table 35. WELL WOMAN/GYNECOLOGY TASKS										
	Frequency				Importance					
Task Statements	N	M	SD	Range	N	M	SD	Range	Unweighted Composite Score	Recommended for Consideration for Elimination by AMCB BOD
152. Gathers information about the woman's personal gynecological history and present health status.	263	4.83	0.43	2	263	3.94	0.24	1	8.77	
153. Evaluates for sexual orientation.	262	4.59	0.83	4	256	3.67	0.59	2	8.25	
154. Evaluates for sexual dysfunction.	260	4.46	0.83	4	257	3.72	0.5	2	8.18	
155. Counsels woman about prevention and recognition of sexually transmitted infections.	262	4.78	0.53	3	262	3.9	0.29	1	8.69	
156. Assesses the woman for high-risk sexual behavior.	261	4.62	0.77	4	259	3.84	0.37	2	8.47	
157. Assesses woman for sexually transmitted infections (e.g., gonorrhea, syphilis, Chlamydia, HPV, HSV, HIV).	259	4.82	0.52	3	259	3.91	0.28	1	8.73	
158. Writes prescription for partner of a women with sexually transmitted infection STI.	262	3.23	1.52	4	206	3.58	0.75	3	6.82	
159. Treats woman for sexually transmitted infections (e.g., gonorrhea, syphilis, Chlamydia, HPV, HSV).	260	4.24	0.96	4	258	3.92	0.27	1	8.16	
160. Treats woman's partner(s) for sexually transmitted infections.	262	3.16	1.54	4	200	3.58	0.74	3	6.74	
161. Removes condyloma using chemical methods.	262	2.08	1.34	4	136	2.88	1.02	3	4.97	
162. Screens for indications and contraindications for various contraceptive methods by history and physical examination and laboratory data.	261	4.87	0.41	3	261	3.91	0.28	1	8.78	
163. Provides detailed information on contraceptive options.	260	4.92	0.32	3	260	3.91	0.3	2	8.83	
164. Provides guidance, instruction and counseling regarding natural family planning methods (e.g. Billings, rhythm, symptothermal and lactational amenorrhea).	259	4.04	1.09	4	254	3.58	0.65	3	7.62	

Table 35. (Continued) WELL WOMAN/GYNECOLOGY TASKS										
	Frequency				Importance					
Task Statements	N	M	SD	Range	N	M	SD	Range	Unweighted Composite Score	Recommended for Consideration for Elimination by AMCB BOD
165. Provides instruction and counseling regarding use of condoms as a method of contraception or STD prevention.	261	4.74	0.61	3	261	3.85	0.38	2	8.59	
166. Provides guidance, instruction, and counseling regarding chemical methods of contraception (e.g., contraceptive foam and sponge).	261	3.35	1.59	4	211	3.29	0.96	3	6.64	
167. Provides diaphragm fitting and instruction.	261	1.68	1.05	4	102	2.62	1.07	3	4.3	
168. Counsels and refers woman for the cervical cap method of contraception.	**260**	**1.53**	**1.01**	**4**	**80**	**2.38**	**1.12**	**3**	**3.92**	**X**
169. Provides cervical cap fitting and instruction.	**258**	**1.31**	**0.79**	**4**	**46**	**2.32**	**1.11**	**3**	**3.63**	**X**
170. Provides guidance and counseling for the prevention and recognition of toxic shock syndrome.	261	2.65	1.41	4	197	3.22	0.85	3	5.87	
171. Administers injectable contraceptive (Depo-Provera).	261	3.38	1.64	4	196	3.31	0.94	3	6.69	
172. Provides paracervical block for IUD insertion.	260	1.41	1.07	4	40	2.22	1.2	3	3.63	
173. Inserts intrauterine devices (i.e., paragard, Mirena IUS).	261	4.22	1.19	4	239	3.81	0.54	3	8.03	
174. Instructs, orders and manages women using oral contraceptives.	260	4.72	0.65	4	258	3.91	0.34	3	8.63	
175. Prescribes oral, injectable and emergency contraceptives.	260	4.24	1.27	4	240	3.85	0.43	3	8.09	
176. Performs implantable contraceptive insertion.	259	3.51	1.65	4	192	3.62	0.78	3	7.13	
177. Counsels and refers the woman for permanent sterilization.	260	3.85	1.13	4	253	3.53	0.68	3	7.38	
178. Evaluates for and performs Essure and/or Adiana permanent sterilization.	**261**	**1.29**	**0.92**	**4**	**29**	**2.05**	**1.15**	**3**	**3.34**	**X**
179. Performs a wet mount or culture for diagnosis of vaginitis.	261	4.38	1.16	4	242	3.78	0.54	3	8.16	

Table 35. (Continued) WELL WOMAN/GYNECOLOGY TASKS										
	Frequency				Importance					
Task Statements	N	M	SD	Range	N	M	SD	Range	Unweighted Composite Score	Recommended for Consideration for Elimination by AMCB BOD
180. Prescribes pharmaceuticals and/or alternative therapies for treatment of vaginitis.	260	4.71	0.62	3	260	3.86	0.38	3	8.57	
181. Treats condyloma using cryotherapy.	261	1.56	1.22	4	59	2.56	1.11	3	4.12	
182. Obtains Papanicolaou test.	259	4.81	0.58	4	256	3.9	0.35	3	8.71	
183. Arranges for colposcopy when physical and/or cytologic findings indicate doing so.	260	4.21	1.02	4	253	3.85	0.45	3	8.06	
184. Performs colposcopy.	**261**	**1.24**	**0.88**	**4**	**20**	**2.37**	**1.14**	**3**	**3.61**	**X**
185. Evaluates woman for menstrual irregularities.	261	4.55	0.79	3	261	3.78	0.46	2	8.33	
186. Performs endometrial biopsy.	261	1.87	1.32	4	96	2.78	1.15	3	4.65	
187. Performs endocervical curettage.	**259**	**1.29**	**0.94**	**4**	**25**	**2.21**	**1.16**	**3**	**3.5**	**X**
188. Performs pre-hysterectomy and post-hysterectomy counseling.	260	1.6	1.26	4	59	2.45	1.2	3	4.05	
189. First assists at GYN surgery.	260	1.12	0.53	3	15	1.86	1.1	3	2.98	
190. Performs the initial assessment and diagnostic procedures for evaluation of infertility.	260	3.05	1.46	4	206	3.25	0.91	3	6.3	
191. Obtains data regarding signs and symptoms of the climacteric/menopause.	261	3.54	1.38	4	231	3.5	0.75	3	7.04	
192. Initiates a plan to manage menopause-related signs and symptoms.	260	3.28	1.42	4	219	3.47	0.76	3	6.75	
193. Prescribes hormone replacement therapy and/or other alternative therapies for treatment of menopause-related symptoms, as indicated.	261	2.7	1.48	4	181	3.28	0.89	3	5.98	
194. Counsels women about management of perimenopausal and menopausal symptoms.	260	3.41	1.35	4	231	3.56	0.7	3	6.97	
195. Assess woman for vulvar disease.	260	3.44	1.37	4	232	3.54	0.73	3	6.98	

Table 35. (Continued) WELL WOMAN/GYNECOLOGY TASKS										
	Frequency				Importance					
Task Statements	N	M	SD	Range	N	M	SD	Range	Unweighted Composite Score	Recommended for Consideration for Elimination by AMCB BOD
196. Performs vulvar biopsy.	261	1.49	1.04	4	63	2.6	1.15	3	4.09	
197. Counsels woman regarding normal physiological and emotional changes throughout the menstrual cycle.	259	4.34	0.95	4	254	3.74	0.52	3	8.07	
198. Provides guidance and counseling for the prevention and recognition of premenstrual syndrome.	256	3.98	1.12	4	245	3.67	0.61	3	7.65	
199. Evaluates and manages woman diagnosed with premenstrual syndrome/premenstrual dysphoric disorder (e.g., dietary and lifestyle modifications, pharmaceuticals, complementary therapies, etc.).	257	3.53	1.26	4	237	3.62	0.67	3	7.15	
200. Refers woman for pelvic ultrasound.	259	3.98	1.09	4	251	3.71	0.54	2	7.69	
201. Performs sexual assault examination.	**259**	**1.24**	**0.76**	**4**	**33**	**2.72**	**1.14**	**3**	**3.96**	**X**
202. Provides counseling and support of woman following a sexual assault.	258	1.96	1.26	4	130	3.42	0.9	3	5.38	
203. Refers for gynecological sonogram.	256	3.77	1.23	4	240	3.62	0.7	3	7.39	
204. Performs gynecological sonogram.	**259**	**1.26**	**0.9**	**4**	**23**	**2.12**	**1.24**	**3**	**3.38**	**X**
205. Prescribes pharmaceuticals for treatment of infertility.	258	1.83	1.32	4	88	2.76	1.15	3	4.59	
206. Performs artificial insemination.	**259**	**1.13**	**0.6**	**4**	**18**	**2.12**	**1.23**	**3**	**3.25**	**X**
207. Expectantly manages ectopic pregnancy (e.g., serial beta-HCG, ultrasound).	257	2.15	1.35	4	138	3.07	1.07	3	5.22	
208. Medically manages ectopic pregnancy (i.e., methotrexate).	258	1.49	0.98	4	72	2.76	1.16	3	4.25	
209. Orders standard screening tests for women (e.g., thyroid function, Tb skin test, mammography, DEXA scan, colonoscopy).	256	4.29	1.02	4	249	3.72	0.62	3	8.01	
210. Orders sonohystogram.	259	1.81	1.24	4	103	2.67	1.16	3	4.48	

Table 36. PRIMARY CARE TASKS										
	Frequency				Importance					
Task Statements	N	M	SD	Range	N	M	SD	Range	Unweighted Composite Score	Recommended for Consideration for Elimination by AMCB BOD
211. Interviews woman about her family history, personal medical, surgical, obstetrical, gynecological, sexual and social history, and pregnancy.	108	4.9	0.39	3	107	3.95	0.21	1	8.85	
212. Assesses and refers woman for risk of domestic violence or sexual abuse.	107	4.54	0.85	4	107	3.93	0.25	1	8.48	
213. Assesses mental and emotional status through the use of history-taking and interviewing techniques.	108	4.85	0.45	3	107	3.91	0.29	1	8.76	
214. Questions and counsels woman regarding use of medications, recreational drugs, smoking, alcohol, and caffeine.	106	4.83	0.45	3	107	3.88	0.38	2	8.71	
215. Develops a treatment plan for substance abuse and refers as indicated.	108	3.34	1.42	4	104	3.43	0.87	3	6.78	
216. Questions and counsels woman about exposure to environmental or work hazards such as toxic chemicals or radiation.	108	3.96	1.26	4	107	3.46	0.79	3	7.42	
217. Examines eyes for abnormalities in pupillary reaction to light and accommodation, uses ophthalmoscope to examine eye grounds; notes extraocular movements.	109	2.65	1.56	4	105	2.74	1.19	3	5.39	
218. Evaluates breasts for abnormalities (e.g., masses, fissures).	108	4.71	0.67	4	107	3.92	0.28	1	8.63	
219. Performs breast biopsy.	**108**	**1.1**	**0.61**	**4**	**107**	**1.99**	**1.21**	**3**	**3.09**	**X**
220. Evaluates for cardiac abnormalities (e.g., murmur, irregularity) and refers as indicated.	108	4.39	1.2	4	106	3.51	0.8	3	7.9	
221. Inspects skin for abnormalities (e.g., discoloration, lesions) and treats as indicated.	108	4.41	1.02	4	107	3.47	0.78	3	7.87	
222. Performs skin biopsy.	**108**	**1.37**	**0.96**	**4**	**106**	**2.2**	**1.18**	**3**	**3.57**	**X**

Table 36. (Continued) PRIMARY CARE TASKS										
	Frequency				Importance					
Task Statements	N	M	SD	Range	N	M	SD	Range	Unweighted Composite Score	Recommended for Consideration for Elimination by AMCB BOD
223. Performs removal of abnormal lesions (e.g., skin tags, nevus) as indicated (e.g., cautery, scalpel, liquid nitrogen).	**108**	**1.77**	**1.22**	**4**	**106**	**2.38**	**1.15**	**3**	**4.15**	**X**
224. Evaluates and manages neurological abnormalities (e.g., headaches) and refers as indicated.	106	3.53	1.47	4	106	3.33	0.91	3	6.86	
225. Evaluates for musculoskeletal abnormalities.	108	3.44	1.57	4	105	3.2	1.03	3	6.64	
226. Performs cortisone injections.	**107**	**1.16**	**0.66**	**4**	**106**	**1.85**	**1.14**	**3**	**3.01**	**X**
227. Evaluates for abdominal abnormalities including palpation, diagnostic imaging, and lab work, as indicated.	106	3.93	1.38	4	107	3.51	0.76	3	7.45	
228. Assesses for signs of genitourinary infection, including physical assessment, laboratory findings, and manages as indicated.	107	4.71	0.57	3	106	3.91	0.32	2	8.62	
229. Examine and evaluates for vaginal, cervical, uterine and adnexal abnormalities (e.g., bimanual exam, diagnostic imaging, laboratory testing).	106	4.8	0.49	3	107	3.93	0.25	1	8.74	
230. Evaluates and manages swelling or varicosities of the extremities.	107	3.54	1.38	4	105	3.31	0.89	3	6.86	
231. Assesses the woman for high risk sexual behavior.	107	4.59	0.78	4	107	3.82	0.45	2	8.41	
232. Educates the woman about safe sexual practices.	107	4.65	0.69	3	107	3.89	0.35	2	8.54	
233. Assesses woman for mood disorders (e.g., anxiety, depression, bipolar disorder, eating disorders).	106	4.62	0.71	4	107	3.83	0.47	3	8.45	
234. Treats woman for mood disorders.	107	3.44	1.39	4	106	3.4	0.85	3	6.84	
235. Assesses and counsels woman regarding sexual satisfaction or dysfunction.	107	4.04	1.11	4	106	3.63	0.62	3	7.67	
236. Provide counseling for sexual disorders.	107	3.29	1.43	4	107	3.44	0.9	3	6.73	

Table 36. (Continued) PRIMARY CARE TASKS										
	Frequency				Importance					
Task Statements	N	M	SD	Range	N	M	SD	Range	Unweighted Composite Score	Recommended for Consideration for Elimination by AMCB BOD
237. Prescribes maintenance medications for chronic medical disorders (e.g., asthma, hypertension, migraine headaches, osteoporosis).	107	3.13	1.35	4	106	3.19	0.99	3	6.32	
238. Orders immunizations based on history, age, and recommendation of appropriate specialty groups.	106	4.16	1.19	4	107	3.66	0.75	3	7.82	
239. Orders standard screening tests for women (e.g., thyroid function, Tb skin test, mammography, DEXA scan, colonoscopy).	106	4.46	0.89	4	107	3.84	0.5	3	8.3	
240. Evaluates and treats minor wounds.	**107**	**2.34**	**1.54**	**4**	**107**	**2.52**	**1.21**	**3**	4.86	**X**
241. Sutures minor wounds.	**107**	**1.73**	**1.34**	**4**	**106**	**2.25**	**1.25**	**3**	3.98	**X**

Table 37. Clinical Tasks Recommended by the AMCB Research Committee to the AMCB Board of Directors for Consideration of Elimination from the AMCB Examination Blueprint	
Antepartum	12. Performs sonogram to rule out fetal abnormality.
	15. Performs biophysical profile.
Intrapartum	53. Administers pudendal anesthesia.
	60. Repairs 3rd degree lacerations.
	61. Repairs 4th degree lacerations.
	62. Repairs lacerations of the cervix.
	77. Delivers baby with forceps.
Postpartum	119. Lance external thrombosed hemorrhoids.
Newborn	149. Performs male infant circumcision.
Well-Woman/GYN	168. Counsels and refers woman for the cervical cap method of contraception.
	169. Provides cervical cap fitting and instruction.
	178. Evaluates for and performs Essure and/or Adiana permanent sterilization.
	184. Performs colposcopy.
	187. Performs endocervical curettage.
	201. Performs sexual assault examination.
	204. Performs gynecological sonogram.
	206. Performs artificial insemination.
Primary Care	219. Performs breast biopsy.
	222. Performs skin biopsy.
	223. Performs removal of abnormal lesions (e.g., skin tags, nevus) as indicated (e.g., cautery, scalpel, liquid nitrogen).
	226. Performs cortisone injections.
	240. Evaluates and treats minor wounds.
	241. Sutures minor wounds.

Table 38. Clinical Tasks Approved by the AMCB Board of Directors for Elimination from the AMCB Examination Blueprint	
Antepartum	12. Performs sonogram to rule out fetal abnormality.
Intrapartum	60. Repairs 3rd degree lacerations.
	61. Repairs 4th degree lacerations.
	62. Repairs lacerations of the cervix.
	77. Delivers baby with forceps.
Postpartum	119. Lance external thrombosed hemorrhoids.
Newborn	149. Performs male infant circumcision.
Well-Woman/GYN	178. Evaluates for and performs Essure and/or Adiana permanent sterilization.
	184. Performs colposcopy.
	187. Performs endocervical curettage.
	201. Performs sexual assault examination.
	204. Performs gynecological sonogram.
	206. Performs artificial insemination.
Primary Care	219. Performs breast biopsy.
	222. Performs skin biopsy.
	223. Performs removal of abnormal lesions (e.g., skin tags, nevus) as indicated (e.g., cautery, scalpel, liquid nitrogen).
	226. Performs cortisone injections.
	240. Evaluates and treats minor wounds.

Table 39. Calculated Test Specifications Weights for the CNM/CM Examination.				
	Suggested Test Specifications		Current Test Specifications	
Category	Percent of Items	Number of Items	Percent of Items	Number of Items
Antepartum	20.8	26	22	28
Intrapartum	21.6	27	21	26
Postpartum	16.8	21	17	21
Newborn	12	15	11	14
Well-Woman/GYN	16	20	17	21
Primary Care	12.8	16	12	15
Total	100	125	100	125

Table 40. Participant Opinion Regarding Percentage of Practice Dealing with Normal vs. Abnormal Conditions.		
What percentage of your overall practice deals with patients with abnormal conditions?		
Year of Task Analysis Study	2017	2012*
Mean	48.35	41.0
SD	21.53	
Range	96	
N	292	
Blank	56	

*The SD, Range, N, and Blank were unavailable.

Table 41. I provide ANTEPARTUM midwifery services		
Response	**N**	**Percent**
Yes	325	93.39
No	23	6.61
Blank	0	0.00
Total	348	100

Table 42. I provide ANTEPARTUM care in (check all that apply)					
	Responses		**Did not respond**		
Setting	**N**	**Percent**	**N**	**Percent**	**Total**
Hospital	181	52.01	167	47.99	348
Outpatient clinic or office	263	75.57	85	24.43	348
Out of hospital birth center	33	9.48	315	90.52	348
In-hospital birth center	2	0.57	346	99.43	348
Home	11	3.16	337	96.84	348
Other	0	0.00	348	100.00	348

Table 43. I provide INTRAPARTUM midwifery services		
Response	**N**	**Percent**
Yes	310	89.08
No	33	9.48
Blank	5	1.44
Total	348	100

Table 44. I provide INTRAPARTUM care in (check all that apply)					
	Responses		**Did not respond**		
Setting	**N**	**Percent**	**N**	**Percent**	**Total**
Hospital	284	81.61	64	18.39	348
Out of hospital birth center	42	12.07	306	87.93	348
In-hospital birth center	7	2.01	341	97.99	348
Home	16	4.60	332	95.40	348
Other	0	0.00	348	100.00	348

Table 45. I provide POSTPARTUM midwifery services		
Response	**N**	**Percent**
Yes	285	81.90
No	22	6.32
Blank	41	11.78
Total	348	100

Table 46. I provide NEWBORN midwifery services		
Response	**N**	**Percent**
Yes	65	18.68
No	237	68.10
Blank	46	13.22
Total	348	100

Table 47. I provide WELL WOMAN/GYNECOLOGY midwifery services		
Response	**N**	**Percent**
Yes	267	76.72
No	34	9.77
Blank	47	13.51
Total	348	100

Table 48. I provide PRIMARY CARE midwifery services		
Response	**N**	**Percent**
Yes	111	31.90
No	183	52.59
Blank	54	15.52
Total	348	100