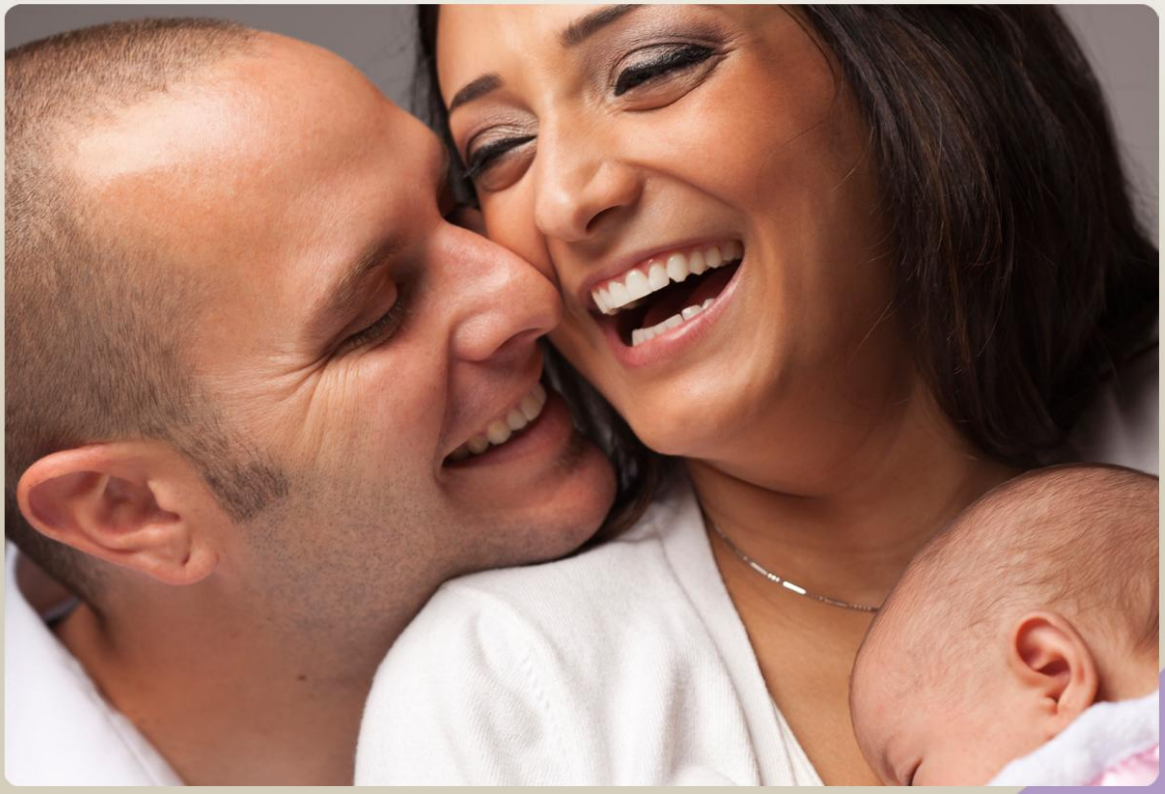
NARM
North American Registry of Midwives

Certified Professional Midwife:

Recognizing a Valued Maternity Care Provider



A Policy Brief by the North American Registry of Midwives
2012

Certified Professional Midwife:

Recognizing a Valued Maternity Care Provider

Executive Summary

Today, while hospital birth is now the norm for most parents, it is not the choice of every family, and there is growing recognition that there should be a range of options for primary maternity care, including the option of midwife-led births at home and in freestanding birth centers.

The Case for Supporting Midwives as Part of Primary Maternity Care

There have been many studies in the U.S. and in other countries that have shown midwife-led, out-of-hospital births to be safe and beneficial. When comparing women who received midwife-led models of care with women who did not, researchers have found no statistically significant differences between the groups for overall fetal loss/neonatal death (Hatem, Sandall, Devane, & Gates, 2008). In addition, researchers have found that women who had midwife-led care were less likely to experience costly interventions such as Caesarean sections (Hatem et al., 2008; Fullerton, Navarro, & Young, 2007; Johnson & Daviss, 2005). The health care system could also benefit from midwives as a solution to projected shortages of obstetricians and to expand access to the kind of prenatal care that could help to reduce the disparities in pregnancy and birth outcomes for vulnerable populations.

About the North American Registry of Midwives (NARM)

NARM is a national nonprofit organization with the mission to provide and maintain an evaluative process for multiple routes of midwifery education and training; to develop and administer a standardized examination system leading to the credential "Certified Professional Midwife" (CPM); to identify best practices that reflect the excellence and diversity of the independent midwifery community as the basis for setting the standards for the CPM credential; to publish, distribute and/or make available materials that describe the certification and examination process and requirements for application; to maintain a registry of those individuals who have received certification and/or passed the examination; to manage the process of re-certification; and to work in multiple arenas to promote and improve the role of CPMs in the delivery of maternity care to women and their newborns

Credentialing Competence: Certified Professional Midwives (CPMs)

There are two branches of the midwife profession in the U.S.: the Certified Nurse-Midwife (CNM)/Certified Midwife (CM) and the Certified Professional Midwife (CPM). Both branches of professional midwives in the U.S. have high standards for nationally accredited certification. The CPM credential uses a competency-based approach to certification, administered by the North American Registry of Midwives (NARM). In order to be certified, all CPM applicants must participate in a minimum number of specified clinical experiences; demonstrate competency in a specified set of knowledge, skills and abilities; and pass the NARM written examination. This process ensures that all CPMs have the required experience, knowledge, and demonstrated competence to provide the Midwives Model of Care (Midwifery Task Force, 2008).

Certified Professional Midwives

This focus on competencies is an approach that has been successfully used not just for professional certification programs, but also throughout higher education for more than four decades. Competency-based approaches are now being embraced by many within higher education, and in health care education, because of a heightened recognition that it is learning that matters, not the amount of time spent in learning activities.

Challenges to the CPM Profession

One significant challenge facing the CPM profession is the need for state licensure of CPMs. Currently, CPMs cannot practice legally in 24 states. Licensure allows for greater quality assurance by establishing clear practice guidelines as well as mechanisms for oversight and review of CPM practice. Licensure protects the public from those who would attempt to provide midwifery services inappropriately. A second challenge is the need for greater diversity within the profession to help address racial and ethnic disparities in outcomes and the costs associated with them.

Policy Recommendations

In order to validate and support CPMs as a critically needed part of our primary maternity care system, and to establish greater accountability for births at home and in birth centers, state legislators and other policy makers need to:

- Establish licensure based on the CPM credential
- Provide oversight of CPMs through a board of midwifery or advisory council/board within existing oversight boards, comprised mostly of licensed midwives and having the authority to set guidelines for CPM practice
- Establish reporting requirements

There are additional strategies to support and encourage the CPM profession and midwife-led models of care through activities that:

- Guarantee CPMs as eligible health care providers under Medicaid and other reimbursement programs
- Provide funding to establish new midwifery educational programs
- Including CPMs in a national registry for maternity care data to allow for research on pregnancy and birth outcomes for planned out-of hospital births compared with similarly low-risk planned hospital births
- Support research to better understand the role of CPMs

Conclusion

Certified Professional Midwives (CPMs) offer a safe and family-centered option for primary maternity care. To ensure that all births that take place outside of the hospital are attended by skilled practitioners, it is critical for states to offer a pathway to licensure for CPMs. This licensure should be based on the CPM credential while also establishing the structures that properly regulate the activities of CPMs as primary maternity care providers. With support from state officials and other leaders, we will expand access to primary maternity care for all women, and we will establish the credentialed midwife and the midwife-led model of care as safe and beneficial options for maternity care in the U.S.

Certified Professional Midwife:

Recognizing a Valued Maternity Care Provider

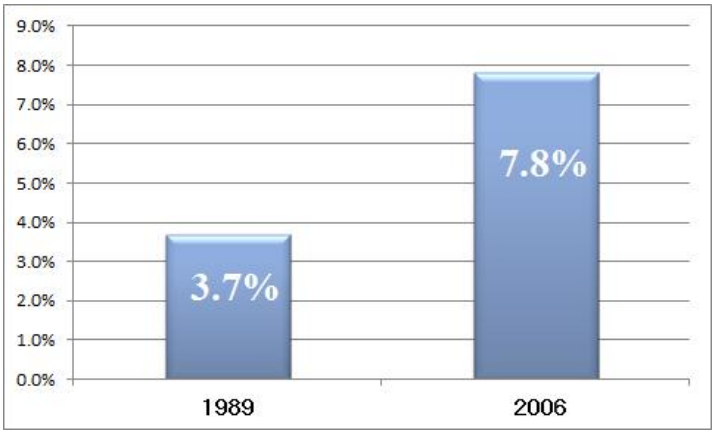
Introduction and Overview

Over the course of the 20th century, the U.S. saw a dramatic change in maternity care, particularly the rise of hospital births. Today, while hospital birth is now the norm for most parents, it is not the choice of every family, and there is growing recognition that there should be a range of options for primary maternity care. This includes the option of midwife-led births at home and in freestanding birth centers. Maternity care by midwives has been described by the World Health Organization as the most cost-effective and appropriate care for all childbearing women (World Health Organization, 1986 and 1999).

World Health Organization's View of Primary Maternity Care

"Midwives are the most cost-effective and appropriate primary care givers for all childbearing women in all instances and in all settings. Home is the most appropriate setting for most childbearing women. Women choosing this option must be provided with necessary diagnostic, consultative, emergency and other services as required, regardless of the place of birth" *(World Health Organization, 1986).*

The percentage of births led by midwives in the U.S. is, in fact, growing, from approximately 3.7% of all births in 1989 (Curtin & Park, 1999) to 7.8% of all births in 2006 (calculated from data presented in MacDorman, Menacker, & Declercq, 2010). Although the majority of these births are attended by certified nurse-midwives in a hospital, research shows that midwife-led births at home and in birth centers are not only safe, but they are also less likely to result in costly and often unnecessary medical interventions (Hatem et al., 2008; Fullerton, Navarro, & Young, 2007; Johnson & Daviss, 2005).



The percentage of births led by midwives in the U.S

This policy brief presents the case for supporting midwife-led births as part of the larger system for primary maternity care, a description of the innovative and competency-based credential required for Certified Professional Midwifes (CPMs), and public policy changes that are needed by state officials and other leaders to establish CPMs and their services as an accepted and transparent part of our primary maternity care system.

The Case for Supporting Midwives as Part of Primary Maternity Care

The midwife-led model of care

The midwife-led model of care begins with the premise that pregnancy and birth are normal life events and that many women seek alternatives to hospital care for normal pregnancy and birth. These premises are supported by the American Public Health Association (APHA) (2001).

Centered on the woman and benefitting both women and their babies, the midwife-led model of care includes:

- continuity of care
- monitoring the physical, psychological, spiritual, and social well-being of the woman and family throughout the childbearing cycle
- providing the woman with individualized education, counseling, and antenatal care
- continuous attendance during labor, birth, and the immediate postpartum period
- ongoing support during the postnatal period
- minimizing technological interventions
- identifying and referring women who require obstetric or other specialist attention (Hatem et al., 2008)

This model of care meets standards set by the World Health Organization (WHO), which defines skilled maternal and neonatal care as "close to where and how [mothers and newborns] live, close to their birthing culture, but at the same time safe, with a skilled professional able to act immediately when complications occur" (WHO, 2005, p. xxi). The WHO states that this care can "best be provided by a registered midwife or a professional health worker with equivalent skills, in midwife-led facilities." The WHO goes on to explain that professional midwives can avert, contain, or solve many of the largely unpredictable life-threatening problems that may arise during childbirth, while working collaboratively with the higher level of care offered by physicians and hospitals when mothers present problems that go beyond a midwife's competency or equipment (WHO, 2005, p. xxi).

How does the midwife-led model of care benefit parents?

There have been many studies in the U.S. and in other countries that have shown midwife-led, out-of-hospital births to be safe and beneficial. A 2008 study by Hatem, Sandall, Devane, and Gates, for example, examined midwife-led births in the U.S. and found there to be "no adverse outcomes" (p. 17). When comparing women who received midwife-led models of care with women who did not, the researchers found that there were no statistically significant differences between the groups for overall fetal loss/neonatal death (Hatem et al., 2008).[i] There are several other studies that support the conclusion that midwife-led births at home and in

Research finds that planned home births have similar outcomes compared to planned low risk hospital births.

birth centers are safe (see summary in Fullerton, Navarro, & Young, 2007), including a prospective cohort study examining the outcomes for Certified Professional Midwives (CPMs), which found that planned home births with CPMs in the United States had similar rates of intrapartum and neonatal mortality as those of low risk hospital births, and medical intervention rates for planned home births were lower than for planned low risk hospital births (Johnson & Daviss, 2005). While research is still needed—particularly to examine the influence of factors like the level of the midwife's education, the risk assessment/transport plan in the case of births at home, and the regulatory environment—the findings to date suggest that planned home births have similar outcomes to planned low risk hospital births.

In addition, researchers have found that women who had midwife-led care were less likely to experience antenatal hospitalization or high-level and costly interventions, such as Caesarean sections (Hatem et al., 2008; Fullerton, Navarro, & Young, 2007; Johnson & Daviss, 2005).

The midwife-led model of care, by treating birth as a normal life event, recognizes that some parents may want to experience birth in a familiar environment and have loved ones be part of that experience. In this model, the parents have the opportunity to make that happen, while also maintaining control over decision making.

Because of these benefits, and the evidence that midwife-led births are safe, some researchers have concluded that midwife-led care "should be the norm for women classified at low and high risk of complications" (Hatem et al., 2008).

How does supporting midwife-led birth benefit society?

Expanding primary maternity care to include midwife-led births would address three societal challenges: the rising rate of Caesarean section births, the current and projected shortage of obstetricians, and disparities in birth outcomes for vulnerable populations.

- **Reducing Unnecessary Birth Interventions.** From 1996 to 2007, the U.S. Caesarean section (C-section) rate increased by 53%, from 21% to 32% (Menacker & Hamilton, 2010). These higher C-section rates are attributed in part to changes in financial access to this service and the prevalence of facility-based births. Not only may there be a tendency to use higher levels of care simply because they are available, but there also may be financial incentives for providers to use them (Fullerton, Navarro, & Young, 2007).

  Many of these C-section births are medically unnecessary, adding avoidable costs to the entire health care system, not to mention physical and emotional burdens on women and their families. Midwife-led births, in contrast, are associated with lower rates of C-section births and other interventions, even when laboring women are transferred to hospitals for complications: C-section rates among women transferred to hospitals range from 1.4% to 17.7%, compared to a range of 13.8% to 28.2% for a comparison group (Fullerton, Navarro, & Young, 2007). A study by the State of Washington

  Midwife-led births are associated with lower rates of Caesarean section births -- and therefore also lower costs to the entire health care system.

Department of Health concluded from a comprehensive review of research findings that greater inclusion of midwife-led models of care into our maternity care system would help reduce the use of unnecessary C-sections, thus lowering the overall cost to the entire health care system (Health Management Associates, 2007).

- **Expanding the System's Capacity for Serving Pregnant Women's Health Care Needs.** The U.S. currently has a shortage of obstetricians (OBs), and that shortage is expected to worsen as more OBs retire, fewer new physicians choose to specialize in obstetrics, and projected demand for women's health care services increases (Rayburn, 2011). The anticipated shortage by 2030 could be as high as 18%, but access to OBs is already lacking in many parts of the country, particularly in rural areas (Rayburn, 2011). This suggests that in order for many U.S. women to access maternity care, midwife-led births should be recognized as an option for parents, and physicians should work collaboratively with midwives.

- **Providing Care that Reduces the Disparities in Outcomes for Low-Income Women and Other Vulnerable Populations.** Expanded use and support of the midwife-led model of care could improve every woman's access to the kind of prenatal care that improves pregnancy and birth outcomes, and this expansion of care can help to reduce the disparities in outcomes that exist for vulnerable populations.

  Currently, outcomes for African American women are striking in that they have much higher infant mortality rates, higher rates of preterm births, and higher rates of low birth weight than other racial/ethnic groups; black women have maternal mortality rates that are three and a half times higher than for white women; American Indian women have higher rates of infant mortality and low birth weight than Hispanic women or non-Hispanic white women; and Asian/Pacific Islander women have higher rates of preterm birth and low birth weight than Hispanic women or non-Hispanic white women (American College of Nurse-Midwives, n.d.).

  Researchers have found that when other at-risk groups (e.g., low-income women) participate in the midwife-led model of care, they have increased access to prenatal care, lower rates of Caesarean births and obstetric interventions, and higher birth weights (Raisler & Kennedy, 2005). By expanding access to the midwife-led model of care to vulnerable and marginalized populations, we may be able to achieve greater equity in outcomes among various populations and reduce overall costs to our health care system.

  When at-risk groups participate in the midwife-led model of care, they have increased access to prenatal care, lower rates of obstetric interventions, and higher birth weights.

Credentialing Competence: Certified Professional Midwives (CPMs)

There are two branches of the midwife profession in the U.S.: the Certified Nurse-Midwife (CNM)/Certified Midwife (CM) and the Certified Professional Midwife (CPM). CNMs/CMs are clinically trained to provide hospital-based maternity care as well as primary and well woman care. CPMs, by contrast, are clinically trained to provide out-of-hospital maternity care, and their scope of practice is limited to the childbearing cycle. Both branches of professional midwives in the U.S. have high standards for nationally accredited certification that distinguish them from "lay midwives," a term used to denote midwives practicing without meeting any formal certification requirements.

Background: The CPM Credential in Context

The CPM credential was developed by the North American Registry of Midwives (NARM) in collaboration with several other midwife organizations and other stakeholders. It uses a competency-based approach to certification. This means the certification requires the student to gain the required knowledge and experience and then demonstrate that she or he has the required skills, knowledge, and competencies needed to provide the midwife-led model of care (as described in Hatem et al, 2008 and also aligned with The Midwives Model of Care as described in Midwifery Task Force, 2008). Rather than imposing a one-size-fits all approach requiring a prescribed set of courses, a competency- based approach focuses on what has been learned and whether a candidate knows how to apply knowledge and clinical skills in various situations.

Focusing on competencies is not new. Such approaches have been successfully used not just for professional certification programs, but also throughout higher education for more than four decades, as described by a 2012 report from the Council for Adult and Experiential Learning (CAEL), *Competency-Based Degree Programs in the U.S.: Postsecondary Credentials for Measurable Student Learning and Performance*. The report notes that in some of the degree programs, students have the option of earning their entire degrees through a demonstration of competencies, rather than participating in a set of required courses. In such programs, "students gain knowledge and skills on their own, with the help of faculty mentors, but they can demonstrate competencies at their own pace and earn a degree based on what they have learned from a variety of sources, including work and other life experiences" (Klein-Collins, 2012, p. 29).

Competency-based credentials vouch for what a student knows and is able to do.

While there is a long history of successful competency-based programs in the U.S., it is only very recently that competency-based approaches have become embraced by many within higher education because of a heightened recognition that it is learning that matters, not the amount of time spent in learning activities. Further, a focus on competencies helps to convey what a credential means. It vouches for what a student knows and is able to do.

The increased focus on competencies is shown in new pilot programs and in the statements of public officials. With funding from Lumina Foundation, for example, several postsecondary institutions and accrediting agencies are working on competency-based assessments related to the foundation's competency framework, the Degree Qualifications Profile. At a recent event hosted by the Center for American

Progress and CAEL, Eduardo Ochoa, assistant secretary for postsecondary education at the U.S. Department of Education, noted that "The department is looking to see competency-based education develop and flourish" (Fain, 2012).

The CPM Credential in Detail

The CPM credentialing process represents an innovative example of professional credentialing of learning and competencies. The CPM is a competency-based credential that is focused on what a student knows and is able to do and is designed around a set of competencies that have been identified by a formal job analysis conducted by NARM every 7-8 years.

The Entry Level Portfolio Evaluation Process (PEP)
Candidates not completing an accredited midwifery program must successfully complete the Entry Level Portfolio Evaluation Process (PEP), which is a comprehensive process for documenting the skills, knowledge, and competencies of the midwife candidate. It includes documentation that the candidate has fulfilled NARM's general education requirements; verification from preceptors that the candidate is proficient in the skills, knowledge, and abilities required by the profession; affidavits from the preceptors that the candidate has developed and utilized practice guidelines, informed consent documents, and an emergency care form; three professional letters of reference; and a passing score on the NARM Skills Assessment. All certification candidates, regardless of route of documentation, must pass the NARM Written Exam.

Applicants may establish their qualifications through multiple routes. Two primary routes are the Portfolio Evaluation Process (PEP) or graduation from a program accredited by the Midwifery Education Accreditation Council (MEAC). The Portfolio Evaluation Process consists of a review by NARM of required documentation provided by the applicant. In this review, a qualified preceptor verifies that she or he has supervised and evaluated the student's learning and demonstration of skills. MEAC-accredited programs are required to incorporate NARM requirements and are reviewed periodically to verify that students are provided with the necessary learning opportunities and evaluated by qualified faculty. The MEAC programs may vary in terms of instructional delivery, including classroom-based courses, online courses, hybrid classroom/online courses, and independent study. In all MEAC programs, clinical training takes place in midwifery practices serving women planning to give birth in homes or birth centers. Graduates of entry-level programs accredited by MEAC may earn a certificate, an associate degree, bachelor's degree, or master's degree in midwifery.

NARM has also evaluated requirements and set criteria for reciprocity for midwives licensed through state established programs that predate the CPM, midwives who have earned the CNM/CM certification, and some internationally educated midwives.

Regardless of which route to the credential is taken, in order to be certified, all CPM applicants must:

1. Participate in a minimum number of specified clinical experiences
2. Demonstrate competency in a specified set of knowledge, skills, and abilities
3. Pass the NARM written examination

All candidates for the CPM must have significant experience in attending out-of-hospital births, prenatal examination, newborn examinations, and postpartum examination. Following an apprenticeship model, all students or graduates of accredited programs and all entry-level portfolio evaluation applicants must document the following minimum requirements:

- Attendance at 10 births as an observer
- An additional 20 births, 25 prenatal visits, 20 newborn exams, and 10 postpartum visits as an assistant under the supervision of a qualified preceptor
- An additional 25 births (5 with continuity of care and 10 others with at least one prenatal visit under supervision), 75 prenatal visits, 20 newborn exams, and 40 postpartum exams as a primary midwife under supervision
- Attendance at a minimum of 5 home births and 2 planned hospital births in any role
- Verification of mastery in over 750 comprehensive core competencies in knowledge and skills essential for safe midwifery practice (NARM Candidate Information Booklet, 2012)

A qualified preceptor who is certified for competence in the knowledge and skills being taught must verify mastery of both skills and clinical experience. In addition, as previously noted, all candidates must also successfully complete the NARM written exam.

The credentialling process ensures that all CPMs have the required experience, knowledge, and demonstrated competence to perform as a skilled midwife

This process ensures that all CPMs have the required experience, knowledge, and demonstrated competence to perform as a skilled midwife. A high-level comparison of the CPM certification requirements with those of CNMs/CMs shows that each midwifery certification route focuses on similar core competencies, establishes similar clinical training requirements, and uses exams nearly identical in terms of content, structure, and depth and breadth of knowledge required (Peterson, 2010).

Other Competency-Based Models in Health Care Professions

Competency-based approaches have been used for other health care professions, most notably in Excelsior College's School of Nursing. Students complete the general education component of the curriculum in a manner similar to all nursing students via campus-based or online courses or credit-by-examination, and then they complete the nursing component of the curriculum by successfully demonstrating achievement of learning through a series of computer-delivered nursing theory examinations and through in-person clinical performance assessments in a simulation lab and with real patients (Klein-Collins, 2012). Students gain learning and clinical skills through independent study and from their own significant work experiences in a clinical setting. Western Governors University and the Oregon Consortium for Nursing Education have also designed nursing programs around competencies that rely on more traditional instructional models (Klein-Collins, 2011).

In addition, there is growing interest in competency-based approaches in medical education as well, as described in the *American Association of Medical Colleges Reporter*. In response to "growing pressures for the

medical profession to respond to society's demands for better, safer health care," there is an interest in finding ways to ensure that medical graduates demonstrate competencies through proper assessments (Sherwin, 2011). Rural medical education programs across the country have adopted apprenticeship models in recent years, with studies showing that the physicians produced through these programs have national examination scores equal to or better than physicians who are educated through traditional classroom-based programs (Peterson, 2010).

The growing recognition of the value of competency-based approaches in higher education—and even in education for health care professions—highlights the value of the CPM credentialing process and its requirement of candidates to demonstrate the competencies needed for professional practice. In addition, this recognition of competency-based approaches may eventually allow for the CPM credential to become more closely aligned with other competency-based education programs within higher education. For example, programs designed around competencies overlapping those of the CPM may grant credit or advanced standing for CPMs interested in continuing their education and training. This could lead to the development of new career pathways and educational opportunities for direct-entry midwives.

Challenges to the CPM Profession

CPMs cannot practice legally in 24 states

Two significant challenges facing the CPM profession are 1) the need for state licensure of CPMs and 2) the need for greater diversity within the profession to help address racial and ethnic disparities in outcomes and the costs associated with them.

The Need for State Licensure

Currently, CPMs cannot practice legally in 24 states. Licensure of CPMs is important because it recognizes CPMs and creates common standards for the profession, thus increasing consumer awareness of who midwives are and what kind of care they provide. Licensure allows for greater quality assurance by establishing clear practice guidelines as well as mechanisms for oversight and review of CPM practice. The American Public Health Association endorses state licensure of direct-entry midwives (APHA, 2001), as does the 2011 Home Birth Consensus Summit Common Ground Statement on Licensure (2011). The International Confederation of Midwives, in its *Global Standards for Midwifery Regulation* (2011), explains that "The primary reason for legislation and regulation is to protect the public from those who attempt to provide midwifery services inappropriately" (p. 1).

The reason licensure is important is clear when considering what happens in its *absence*. When parents do not have access to licensed CPMs, yet still feel strongly about having the option of midwife-led births at home or in birth centers, those parents must use unlicensed midwives or give birth unattended. In these circumstances, there is a significant loss of accountability and a potential threat to patient safety.

The Need for Greater Diversity to Address Disparities in Outcomes

A second challenge is the lack of racial and ethnic diversity in the profession. NARM's records of candidate applications indicate that less than 6% of CPMs self-identify as people of color. The percentage of home births for non-Hispanic white women (.86%) was about three times that for non-Hispanic black, American Indian, and Asian or Pacific Islander women (.25–.31%), and about four times that for Hispanic women (.19%) (MacDorman, Menacker, & Declercq, 2010).

The American College of Nurse Midwives (ACNM) has observed that "representation of diverse groups in [midwifery] ranks strengthens opportunities for providing midwifery care to otherwise underserved communities" (ACNM, n.d., p. 4). As noted earlier, access to the midwifery-led model of care throughout the birth cycle has the potential to reduce the disparities in outcomes that we see among different socio-economic groups. By creating viable pathways to the midwifery profession for all racial and ethnic groups, we may be able to provide better primary maternity care to vulnerable and underserved populations and reduce overall costs to our health care system.

State Policy Recommendations

In order to validate and support CPMs as a critically needed part of our primary maternity care system, and to establish greater accountability for births at home and in birth centers, state legislators and other policy makers need to establish licensure based on national certification while setting up the proper systems to regulate and oversee the profession.

The recommendations in this policy brief echo many of those that have been put forward in previous publications, such as:

- *The Future of Midwifery* (1999), which included the recommendations made by consensus of an expert task force supported by The Pew Charitable Trusts
- *Evidence-Based Maternity Care: What It Is and What It Can Achieve* (2008), by Carol Sakala and Maureen P. Corry (known informally as the Milbank Report)
- *Blueprint for Action: Steps Toward a High-Quality, High-Value Maternity Care System,* includes recommendations resulting from a 2009 national symposium of over 100 leaders with various stakeholder perspectives
- Nine Common Ground Consensus Statements from the 2011 Home Birth Consensus Summit, attended by stakeholders from nine sectors

Model legislation should:

- **Establish Licensure Based on the CPM Credential:** NARM has noted that licensure ensures high quality maternity care to women and their families. This is because licensure is "a mechanism by which members of the midwifery profession are held accountable to the public for providing safe care that is consistent with the scope of practice defined by the profession and upheld by state law and subsequent regulatory guidelines" (NARM, 2012b, p. 2). The evidence-based requirements for practical experience, demonstrated competencies, and didactic learning recommend the NARM credential as the basis for state licensure. Some states may choose to add additional requirements as appropriate.

- **Provide Oversight of CPMs through a Board of Midwifery or Advisory Midwifery Council/Board within Existing Oversight Boards.** The specific regulations regarding the practice of CPMs should be defined and supervised by a state-level board. The primary objective of this board is to protect consumers from unsafe practitioners by "ensuring that minimum standards have been met by all practitioners who are authorized to provide health care services" (Reed & Roberts, 2000, p. 148). The board's responsibilities include evaluating licensure applications, issuing licenses, setting safety standards, and holding disciplinary hearings.

  The board should be comprised mostly of licensed midwives. While there may be physicians, nurses, and consumer representatives also serving on the board, the majority must be midwives who have a deeper understanding of the profession's standards and scope of practice.

  The Board of Midwifery should have the authority to set all guidelines for CPM practice in the state. In particular, the board should define terms and scope of practice; define the conditions suitable for consultation or transfer of care;[ii] and establish guidelines for risk assessment (i.e., consultation or referral for cases that deviate from normal).

  The board may also specify other important guidelines for midwife practice, including immunity for a consulting physician or hospital,[iii] Medicaid or insurance reimbursement for midwife services, and establishing "Shared Decision Making" and "Informed Consent" with the patient (see sidebar).

Informed Consent and Shared Decision Making

The North American Registry of Midwives recognizes *Shared Decision Making* and *Informed Consent* as the cornerstones of woman-centered midwifery care. Midwives want their clients to make well-informed choices about their care. For effective informed consent, midwives provide a combination of decision making tools, including verbal communication and well written documents that are based on evidence-based research and the midwife's clinical expertise.

The Informed Consent Process occurs throughout care during which the plan of care for each client is continuously explored and explained.

Shared Decision Making is the collaborative process that engages the midwife and client in decision making with information about treatment options, and facilitates the incorporation of client preferences and values into the plan of care.

Source: http://narm.org/accountability/informed-consent/

- **Establish Reporting Requirements.** Midwives should be required to submit data on their patients' birth plans and outcomes to state or national registries as a condition of licensure.

Additional Recommendations to Support CPMs

Although the licensure of CPMs falls under the authority of state policy makers, there are additional strategies through which public agencies, nonprofit organizations, and philanthropy can support and encourage the CPM profession and midwife-led models of care.

- **Guarantee CPMs as Eligible Health Care Providers under Medicaid and Other Reimbursement Programs.** CPMs should be named as eligible providers under programs like Medicaid, similar to status of CNMs/CMs. With this change, in states where CPMs are licensed, families would have access to funding to pay for CPM services. States would benefit from this change because of the lower comparative cost of midwife services. Other reimbursement programs should similarly recognize CPMs as eligible providers. These changes in eligibility would help to support the growth and diversity of CPMs as well as the recognition of CPM-provided care as a valued part of the maternity care system.

- **Provide Funding to Establish New Midwifery Educational Programs.** The development of new midwifery education programs, particularly in parts of the country where accredited programs are currently not available, is needed to assure an adequate workforce in coming years. These programs would also open new pathways to the profession and the CPM credential so that the midwife-led model of care is an option for more women, particularly in underserved communities.

- **Include CPMs in a National Registry for Maternity Care Data.** Part of the challenge in understanding the safety and benefits of the midwife-led model of care in the U.S. is that there is no comprehensive national registry for maternity care data that could report on pregnancy and birth outcomes for planned out-of-hospital births compared to similarly low risk planned hospital births. The National Institutes for Health (NIH) should establish such a registry and encourage states to provide data on an annual basis. The NIH could also collaborate with the two large databases that already exist on out-of-hospital births in the U.S., one managed by the Midwives Alliance of North America (MANA) and the other by the American Association of Birth Centers (AABC).

  There should be more research on and understanding of the midwife-led model of care.

  For a national registry, the NIH should partner with organizations that are currently working to establish standard definitions for obstetrics data and vital statistics. For example, since June 2011, the American College of Obstetricians and Gynecologists, the American Board of Obstetrics and Gynecology, the American Society for Reproductive Medicine, the American Urogynecologic Society, the Society for Gynecologic Oncologists, and the Society for Maternal Fetal Medicine have formed the Women's Health Registry Alliance to work on this issue. The NIH should build on the work of this alliance and include standard reporting definitions that would allow for better research on and understanding of the midwife-led model of care.

- **Support Research to Better Understand the Role of CPMs.** Public agencies, nonprofit organizations, and philanthropy can also support a better understanding of the midwife-led model of care through the funding of research. Examples of research that could be funded include:
    - Qualitative studies on women's experience of working with a CPM
    - Research on how the midwife-led model of care has an impact on access to prenatal care; the quality of care throughout the birth cycle; and birth outcomes, including the rate of high-level birth interventions
    - Research on CPMs and risk assessment, particularly the ways in which they assess and handle risk (e.g., critical thinking skills and safety net health system support) when higher level care is needed
    - Research on how women from different socio-economic groups choose their care providers and the impact of informed choice on those decisions
    - Medicaid demonstrations that could examine new ways of restructuring health system relationships, risk-adjusting payments, and providing consumer incentives to choose higher value caregivers and services (Romano, 2012).

Conclusion

Certified Professional Midwives (CPMs) offer a safe and family-centered option for primary maternity care—an option that not only supports planned births at home and in birth centers, but also can help to address projected shortages in maternity care providers and expand access to maternity care for vulnerable populations. CPMs are certified using a competency-based approach to the profession that requires candidates to have extensive hands-on clinical experience in out-of-hospital settings, demonstrated competence, and thoroughly assessed didactic knowledge. To ensure that all births which take place outside of the hospital are attended by skilled practitioners, it is critical for states to offer a pathway to licensure for CPMs. This licensure should be based on the CPM credential while also establishing the structures that properly regulate the activities of CPMs as primary maternity care providers. There are additional strategies to expanding access to midwives and high-quality, cost-effective care. These strategies include designating CPMs as eligible health care providers and providing resources to educate and certify more CPMs. Through these changes, we will expand access to primary maternity care for all women, and we will establish the credentialed midwife and the midwife-led model of care as safe and beneficial options for maternity care in the U.S.

Acknowledgments

Contributing to this policy brief were Brynne Potter, CPM, and Ida Darragh, CPM, of NARM, along with Becky Klein-Collins of CAEL. Additional reviewers included Wendy Gordon LM, CPM, MPH, Jo Anne Myers-Ciecko MPH, Susan J.Myers, LM, CPM, MPH, Katherine Prown, PhD, Geradine Simkins, CNM, MSN, Shannon Anton, CPM, Miriam Khalsa, CPM, Elan McAllister, Carol Nelson, CPM and Debbie Pulley, CPM.

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Additional Resources

For more information about the value of state licensure for CPMs, see NARM's 2012 Position Statement, "State licensure of Certified Professional Midwives. Position Statement," http://narm.org/wp-content/uploads/2012/05/State-Licensure-of-CPMs2012.pdf
For more information about the CPM certification, see NARM's Candidate Information Booklet, http://narm.org/wp-content/uploads/2012/06/CIB0612.pdf
For general information about NARM, see the NARM website. www.narm.org or contact info@narm.org.

Notes

[i]When breaking down these outcomes, the researchers further found that women randomized to receive midwife-led models of care were less likely to experience fetal loss before 24 weeks' gestation, and there were no statistically significant differences between groups for fetal loss/neonatal death of at least 24 weeks (Hatem et al., 2008).
[ii]In Washington State, licensed midwifes and the Midwives' Association of Washington State developed a document titled "Planned Out-Of-Hospital Birth Transport Guidelines." These guidelines have been reviewed and approved by members of the Statewide Perinatal Advisory Committee, the Midwives' Association of Washington State, and the Physician-Licensed Midwife Work Group. See www.washingtonmidwives.org
[iii] See Virginia state law for an example of immunity for physicians, http://mana.org/laws/laws_va.htm.