Meeting the Nation’s Primary Care Needs

Current and Prospective Roles of Doctors of Chiropractic and Naturopathic Medicine, Practitioners of Acupuncture and Oriental Medicine, and Direct-Entry Midwives

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Direct-Entry Midwives
Chapter Only

Developed through the Primary Care Project of the
Academic Consortium for Complementary and Alternative Health Care

In Collaboration with the:
Midwifery Education Accreditation Council

December 2013

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Executive Summary

Context: The United States faces a growing shortage of primary care providers. An emergent theme in many, if not most, of the proposals to address this need is the importance of examining the use of non-medical doctor (M.D.) practitioners. However, workforce analyses and healthcare delivery practices have not to date engaged the potential contributions of four licensed disciplines that are already frequently accessed by significant numbers of people as their first choice, primary provider of care. These are the doctors of chiropractic and naturopathic medicine, practitioners and doctors of acupuncture and Oriental medicine, and direct-entry midwives.

Goal: The goal of this paper is to open a dialogue to assist policymakers, regulators, third-party payers, delivery system administrators, practitioners, and other concerned parties as well as the disciplines themselves in considering the optimal use of these professions as part of the nation’s primary care matrix.

Methods: The Board of Directors of the Academic Consortium for Complementary and Alternative Health Care (www.accahc.org), the membership of which includes most of the councils of colleges, accreditation agencies and certification and testing organizations from these four disciplines, endorsed the project and named the project directors. These co-directors created partnerships with councils of colleges from three of the professions and the accrediting agency from the fourth field. Each organization named a writing team to represent it on the project. These teams collaborated with the co-directors to set the dimensions of the discipline-specific chapters which would guide the writing teams. The teams developed a template of fourteen fields to be addressed within 5500 words. At least one field worked directly with its national professional organization. Each discipline specific chapter was subsequently endorsed by the relevant partner organizations. The analysis and recommendations were in turn endorsed by the ACCAHC Board of Directors prior to publication.

Findings: The approximately 107,500 licensed practitioners in these fields belong to disciplines with an existing, strong, self-identification as providers of primary care. Most of their clinical encounters are the result of patients seeking out practitioners of these disciplines as their initial choice for dealing with a health concern or problem. The existing accreditation standards for each of the disciplines recognize, to at least some significant degree, a broad scope of practice with educational requirements that encompass prevention and public health and treatment of acute conditions, as well as the management and co-management of chronic conditions. In numerous jurisdictions, some of these disciplines are already legally recognized as primary care providers. Some are currently included in medical home planning and programs to stimulate provision of primary care services to the underserved. As such, these disciplines presently relieve some of the burden on the primary care system. Generally unrecognized by the conventional medical community and workforce planners, these practitioner groups represent a hidden dimension of primary care in the United States.
Recommendations from the Project Co-Directors as Endorsed (abridged*):

To the Leaders of the Disciplines of Chiropractic, Naturopathic Medicine, Acupuncture and Oriental Medicine and Direct-Entry Midwifery:

Clarify your discipline’s relationship with primary care in conventional medicine by identifying gaps in training and specify how these gaps might be addressed. Explicitly distinguish those in the discipline who work in primary care from those who prefer to work as specialists. Promote and engage research that will assist all stakeholders in understanding your discipline's role in helping meet primary care needs.

Specify the extent to which your discipline encompasses a distinct model of primary care, and clarify the unique contribution this approach can make to conventional primary care practice and coordinated care provided in patient-centered medical homes.

To Health Workforce Planners, Healthcare Professionals from Other Fields, Policymakers, Public and Private Funders, Government Agencies, and Other Stakeholders:

Prioritize learning about this hidden dimension of primary care delivery via funding and engaging high quality health services and epidemiological research on those individuals and families whose “first choice” for treatment is a licensed practitioner from one of these four disciplines.

Use and examine the contributions of these practitioners to patient satisfaction, quality of life, and cost in limited population primary care strategies (such as for the birth process, or for back pain) and in patient-centered medical homes. Treat the present inclusion of these practitioners as primary care providers as pilot projects from which all stakeholders can learn.

To All Stakeholders:

Utilize the separate chapters delivered in this project as the basis of more multi-stakeholder, inter-professional working summits where each discipline can further develop a strategy that will help guide these professions into a more appropriate relationship with the nation’s primary care matrix. Such a summit would optimally be convened by an independent agency. Recommendations would be bilateral: to the disciplines and to each of the principal stakeholders in the healthcare policy, regulatory, payment and delivery system.

*From the full recommendations endorsed by ACCAHC Board of Directors on page 21
A Note on Names of Members of the Disciplines

Various names are used for professionals in each of these disciplines due to such factors as state requirements, professional associations and personal preferences. Most of those are utilized one or more times in this document.

**Acupuncture and Oriental medicine:** acupuncture, practitioner of acupuncture and Oriental medicine, practitioner of traditional Chinese medicine, Oriental medical doctor, and acupuncture physician.

**Chiropractic (medicine):** chiropractor, doctor of chiropractic, chiropractic doctor, chiropractic physician

**Midwifery:** midwife, direct-entry midwife, certified professional midwife

**Naturopathic medicine:** naturopathic physician, naturopathic doctor, naturopathic medical doctor, doctor of naturopathic medicine, naturopath
Direct-Entry Midwifery and Primary Maternity Care

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Endorsed by the
Midwifery Education Accreditation Council

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Introduction

Midwives are primary maternity care providers. Primary maternity care is not a term widely recognized in the United States but the concept is gaining ground as maternity care reform has become the focus of various federal and private initiatives. In Canada, the Multidisciplinary Collaborative Primary Maternity Care Project provides the following definition:

“Primary maternity health care is the umbrella term for the fundamental healthcare services that women access during pregnancy, childbirth and the postpartum period. Primary maternity health care takes a holistic, women-centered approach to service delivery, health promotion and the prevention and treatment of disease and illness. Primary maternity care is the first contact with our health care system for maternity care needs. Primary maternity health care is part of a comprehensive maternity care system for a community and includes plans for addressing the needs of women and their infants who need care from other providers. It is based on the philosophy that pregnancy and childbirth are natural processes that require a focus on health and should be individualized. Within the context of primary health care, it is an important way of working towards developing health communities.”

In 1986, a World Health Organization (WHO) report affirmed the value of primary care provided by midwives for every birth setting, including home birth, stating:

“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.”

In 2008, the Cochrane Collaborative conducted a systematic review of the international literature to compare midwife-led models of care with other models of care for childbearing women and their infants. The authors found that “Midwife-led care confers benefits and shows no adverse outcomes. It should be the norm for women classified at low and high risk of complications. . . . Policymakers who wish to achieve clinically important improvements in maternity care, particularly around normalizing and humanizing birth, should consider midwife-led models of care.”

Increasing women’s access to quality midwifery care has become a focus of global efforts to realize the right of every woman to the best possible health care during pregnancy and childbirth. The UNFPA and 30 partner organizations produced The State of World’s Midwifery 2011: Delivering Health, Saving Lives.
Direct-Entry Midwifery and Primary Maternity Care

with a call to strengthen and expand the profession.\(^5\) Responding to the challenge, the International Confederation of Midwives has adopted global standards for midwifery education and regulations which are now being used as core references in countries around the world.\(^6\)

In the United States, there are two broad categories of midwives – direct-entry midwives and nurse-midwives. Both types of midwives provide primary maternity care. Certified Nurse-Midwives may also provide primary care to women in all jurisdictions; while direct-entry midwives may, in certain jurisdictions, provide well-woman care and family planning services beyond the childbearing period. This chapter focuses on direct-entry midwives, particularly Certified Professional Midwives, and their role in primary maternity care.

Most direct-entry midwives in the U.S. are state licensed midwives and/or nationally-certified by the North American Registry of Midwives (NARM) as Certified Professional Midwives (CPM). Direct-entry midwives generally practice independently; provide care for women throughout the childbearing cycle; attend births at home or in freestanding birth centers; conduct postpartum home visits for the mother and newborn; and provide breastfeeding support. Their scope of practice in some states includes well-woman care and family planning services. Direct-entry midwives consult with other healthcare professionals and transfer care when indicated.

**Internal Definitions of Primary Maternity Care**

“Certified Professional Midwives are trained and credentialed professionals who offer primary maternity care to women and families across the United States,” according to an issue brief published in 2008 by the leading organizations in the field.\(^7\)

The North American Registry of Midwives is the credentialing agency for CPMs. All candidates for the CPM credential must demonstrate competence in the knowledge, skills and abilities necessary to midwifery practice, which encompass general healthcare skills; midwifery education, counseling and communication; maternal health assessment; labor, birth and immediate postpartum care, including newborn assessment; postpartum care, including well-baby care. The specific requirements are based on a national job analysis, first conducted in 1995 when several hundred practicing midwives were asked about the types of care that they provided; the results of that comprehensive survey ultimately served to define entry-level standards of midwifery competency. The CPM competencies specifically addressed the primary maternity care functions provided by direct-entry midwives to mothers and newborns, and the CPM credential quickly became a recognized standard for midwives practicing in out-of-hospital settings. The CPM competencies, updated by subsequent job analyses, also became an essential framework for the accreditation of formal direct-entry midwifery education programs.\(^8,9\)

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The Midwives Alliance of North America (MANA), a broad-based alliance representing midwives from diverse educational backgrounds and credentialing status, first adopted core competencies in 1994 and revised the document in 2011. The core competencies include a set of guiding principles regarding health, pregnancy and childbirth, and related statements regarding the role and responsibilities of the midwife, described as an autonomous practitioner who works in partnership with women and collaborates with other healthcare and social service providers when necessary. The core competencies, like the knowledge, skills and abilities identified by NARM, address the scope of practice of the midwife and clearly situate the practice within primary maternity care.10

The Midwifery Education Accreditation Council (MEAC) is an accrediting agency for direct-entry midwifery education recognized by the U.S. Department of Education. MEAC Standards for Accreditation include curriculum requirements which are based on the essential knowledge and skills identified by NARM and core competencies articulated by MANA.11

The National Association of Certified Professional Midwives (NACPM) is the professional association that represents CPMs. In 2004, the NACPM adopted essential documents that describe the philosophy, scope of practice, and standard of care for CPMs. Again, the role of the midwife described in these documents clearly establish the midwife as a primary maternity care provider, a professional who assumes responsibility for the care of childbearing women, has a role in health promotion and education, and practices within a network of relationships with other care providers who can provide service outside the scope of midwifery practice when needed.12

The International Confederation of Midwives describes the midwife thus:

“The midwife is recognized as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labor and the postpartum period, to conduct births on the midwife’s own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.”

“The midwife has an important task in health counseling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women’s health, sexual or reproductive health and child care. A midwife may practice in any setting including the home, community, hospitals, clinics or health units.”13

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This definition is consistent with the Midwives Model of Care™ which has been endorsed by all the leading organizations involved in direct-entry midwifery education and certification, and professional issues in the U.S. The Midwives Model of Care™ asserts that pregnancy and birth are normal life events. It includes:

- Monitoring the physical, psychological and social well-being of the mother throughout the childbearing cycle;
- Providing the mother with individualized education, counseling and prenatal care, continuous hands-on assistance during labor and birth, and postpartum support;
- Minimizing technological interventions; and
- Identifying and referring women who require obstetrical attention.

The application of this model has been proven to reduce the incidence of birth injury, trauma and cesarean section.14

Internal Discussions over Primary Maternity Care

There appears to be widespread agreement within the profession when describing midwives as primary maternity care providers. There is much less agreement about the role that midwives could play, should play or, in some cases, actually do play in the provision of primary care beyond the childbearing cycle.

In the 1990s, Certified Nurse-Midwives moved to expand their scope of practice to include primary care for women across the lifespan from adolescence beyond menopause, with a special emphasis on pregnancy, childbirth, and gynecologic and reproductive health. The Core Competencies for Basic Midwifery Practice of the American College of Nurse-Midwives include primary health care for women and management of common health problems.15 Educational programs that prepare Certified Nurse-Midwives must incorporate a certain number of clinical experiences specific to primary care, including common health problems, family planning and gynecologic visits.16 It is unclear what percentage of practicing Certified Nurse-Midwives is actually providing primary care beyond the childbearing period.

Certified Professional Midwives may also provide family planning and gynecologic care in certain jurisdictions and many would like to see the scope of practice and training expanded in order to serve women's health needs more broadly. While most licensed CPMs have access to a specific list of drugs, none currently have prescriptive privileges. There are some who argue that one cannot be an effective primary maternity care provider without the ability to treat certain infections and diseases without referring to another provider. It would certainly be helpful if the scope of practice was expanded as above.

Practice Model, Including Referral and Co-management

Professional midwifery’s independent scope of practice generally limits care to normal, low-risk women and newborns and mandates the timely and appropriate utilization of obstetrical experts and facilities when indicated, in the form of consultation, referral, transfer or co-management of care.

NACPM states that “Certified Professional Midwives are trained and credentialed to offer expert care and support to women and their babies for pregnancy, birth and the postpartum period. CPMs practice as autonomous health professionals working within a network of relationships with other maternity care professionals who can provide consultation and collaboration when needed.”17 The NACPM Scope of Practice notes that the midwife must have a plan for consultation and referral when these conditions arise. When needed, the midwife can provide emergency care and support for mothers and babies until additional assistance is available.18

NARM further expects that each midwife provides her clients with a care plan that is informed by her training, competency, practice guidelines, regional community standards of both medical and midwifery maternity care providers, and legal requirements. The Plan of Care includes both written and verbal communication and is revisited throughout the course of care as changes occur.

CPMs screen women throughout their pregnancy, labor, birth and postpartum for signs of illness or complications that require care beyond the scope of midwifery, the individual midwife’s guidelines, and/or the relevant state laws.19 Guidelines specifying clinical conditions necessitating involvement of an obstetrical specialist might include complications such as chorioamnionitis, gestational diabetes uncontrolled by diet and exercise, preeclampsia, fetal distress, prolonged labor, and severe postpartum hemorrhage. Certain states such as Vermont have adopted very specific regulations for midwifery practice and referral while others such as Montana allow for more discretion.20,21 In other cases, state midwifery professional associations like the Midwives Association of Washington State have adopted guidelines for consultation and referral.22

The majority of women seeking care by a CPM are planning to have their babies at home or in a freestanding birth center. Therefore, the CPM must also be prepared to make appropriate referrals and arrange transport when a woman under her care requests or requires services that can only be provided in hospital. According to data collected from CPMs, approximately 12% of women who begin the process of a planned out-of-hospital birth require transfer to an acute-care hospital either during labor, or during the immediate postpartum period. Most of these transfers are for non-emergent conditions.23

To strengthen the integration of home birth services and improve collaboration and referral among providers, a Home Birth Consensus Summit was convened in October 2011. The summit brought together a cross section of stakeholders, including midwives, physicians, public health researchers and consumers, for three days of consensus building dialogue which resulted in nine common ground statements. Topics included collaboration, regulation and licensure, physiologic birth, health disparities and equity, liability, research and data collection, and interprofessional education. As a result, several multidisciplinary projects have been initiated to take action on the consensus statements by various means, including development of transport protocols, enhancing access to Medicaid coverage across maternity care settings, developing birth place decision aids for women, home birth data collection and research, and development of curricula to expose all maternity professionals to all settings and types of providers.24

**Evidence of Patient Use as First Contact Provider**

Women seek midwives and find them without referral. Typically referral to a midwife via a medical “gatekeeper” is not required.

Formal surveys querying patients about their perception of midwives as first contact providers have not been undertaken. However, conversations with midwives and midwifery clients demonstrate that midwifery clients consistently express a strong preference for receiving pregnancy-related care, well-woman gynecologic exams and family planning care from their midwives. Where midwives do not or cannot receive third-party reimbursement, clients frequently pay out-of-pocket for midwifery care, in spite of the fact that they could obtain that same care at a reduced cost within their own health maintenance organization, insurance network, or even Medicaid.

**Evidence of Wellness, Health Promotion and Primary Prevention Services**

Patient education, behavioral change, risk assessment, health promotion and primary prevention are at the heart of the Midwives Model of Care™. Commitment to the values inherent in this model of care is demonstrated in the NARM Skills and MANA Core Competencies as well as the NACPM Standards of Practice.

In a report summarizing the best available research on maternity care, the authors remarked that “by learning from those with the skills and knowledge to enhance the innate physiologic capacities of the childbearing process, we can refrain from exposing mothers and babies to the harm and expense of avoidable interventions and use medical interventions appropriately as needed.” They described the results of a large prospective study of American women who gave birth with CPMs and remarked on the striking differences in the rates of interventions when compared to low-risk American women who received the usual (non-midwife) care. “The low CPM study rates of intervention are benchmarks for what the majority of childbearing women and babies who are in good health might achieve.”25,26

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The Coalition for Improvement of Maternity Services recommends that all birthing mothers should be offered unrestricted access to professional midwifery care. This recommendation is supported by a two-year research project by a team of maternity care experts that conducted a comprehensive review of the scientific literature. The researchers found that the use of midwives was associated with:

- Increased length of prenatal visits, more education and counseling during prenatal care, and fewer hospital admissions.
- Less need for analgesia and/or epidural anesthesia and increased use of alternative pain relief methods, as well as more freedom of movement in labor and intake of food and drink.
- Decreased use of amniotomy (membrane rupture), IVs, electronic fetal monitoring; fewer inductions and augmentations of labor; and fewer injuries of the perineum (tissue between vagina and anus) as shown by fewer episiotomies, fewer rectal tears, and more intact perinea.
- Fewer cesareans overall, including fewer emergency cesareans for fetal distress or for inadequate progress in labor, and more vaginal births after cesareans (VBACs).
- Fewer infants born preterm, low birth weight or with complications such as birth injury or requiring resuscitation after birth, and more infants exclusively breastfeeding at 2-4 months after birth.27

The International Confederation of Midwives further elucidates the contributions made by midwives in their Essential Competencies for Basic Midwifery Practice, revised in 2011:

- There are a number of key midwifery concepts that define the unique role of midwives in promoting the health of women and childbearing families. These include:
  - Partnership with women to promote self-care and the health of mothers, infants, and families;
  - Respect for human dignity and for women as persons with full human rights;
  - Advocacy for women so that their voices are heard;
  - Cultural sensitivity, including working with women and healthcare providers to overcome those cultural practices that harm women and babies; and
  - A focus on health promotion and disease prevention that views pregnancy as a normal life event.28

**Governmental or Regulatory Agency Recognition as Primary Maternity Care Providers**

Direct-entry midwives, including CPMs, are currently licensed in 26 states. In most states they are licensed to provide primary maternity care as independent providers. The language of the laws may not specifically refer to primary maternity care but the scope of practice clearly establishes the midwife as a primary maternity care provider. Twenty states utilize the CPM credential or recognize the CPM credential plus state-specific requirements as the basis for state licensure, certification or registration. Several states refer specifically to the NACPM Standards of Practice in statute or regulations.29

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In Washington State, Licensed Midwives are recognized as primary care health professionals eligible to participate in the Washington State Health Professional Loan Repayment and Scholarship Programs. Both programs were created to attract and retain health professionals to serve in critical shortage areas in the state. It does not appear that anyone has undertaken an investigation of state laws or state agencies to determine whether Licensed and/or Certified Professional Midwives are specifically recognized as primary care providers in other states.

**Third-Party Payer Recognition as Primary Maternity Care Providers**

In several states, such as Virginia, Licensed and/or Certified Professional Midwives may enroll as Medicaid (or in California, Medi-Cal) providers. Insurance companies often reimburse for care by Licensed Midwives at out-of-network rates and, at times, a client can secure in-network coverage for an out-of-network provider. Such an exception is generally classified as either medical (i.e., no providers within the network provide out-of-hospital maternity services) or geographical (providers within the network who provide out-of-hospital services are geographically too far away to be feasible choices for the insured).

In the State of Washington, an “every category of provider law” mandates that health plans must include Licensed Midwives if the services within their scope of practice are covered by the plan. Health carriers must also allow women direct access to the type of healthcare practitioner of their choice for women’s healthcare services, including Licensed Midwives, without requiring a prior referral. Midwives and clients in other states are working to ensure mandatory third-party reimbursement for Licensed and/or Certified Professional Midwives.

At the federal level, CPMs are gaining visibility and received an early indication of recognition in the Patient Protection and Affordable Care Act passed in March 2010, which mandates Medicaid reimbursement of all licensed providers, including licensed midwives, working in licensed birth centers. In March 2011, Congresswoman Chellie Pingree (ME) introduced the “Access to Certified Professional Midwives Act” which would amend Title XIX of the Social Security Act to provide access to Certified Professional Midwives for women enrolled in the Medicaid program.

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Research Relative to Midwives as Primary Maternity Care Providers

Published research on direct-entry midwifery and CPMs has focused on safety, quality, and cost-effectiveness. The largest study undertaken on practices by Certified Professional Midwives found that planned home births with Certified Professional Midwives in the United States “had similar rates of intrapartum and neonatal mortality to those of low risk hospital births” and that “medical intervention rates for planned home births were lower than for planned low risk hospital births.” The authors stated:

“Our study of certified professional midwives suggests that they achieve good outcomes among low risk women without routine use of expensive hospital interventions. Our results are consistent with the weight of previous research on safety of home birth with midwives internationally. This evidence supports the American Public Health Association’s recommendation to increase access to out of hospital maternity care services with direct entry midwives in the United States. We recommend that these findings be taken into account when insurers and governing bodies make decisions about home birth and hospital privileges with respect to certified professional midwives.”36

Even more recently, the Department of Health of the State of Washington contracted with a private consulting group to conduct a study weighing the economic costs and benefits of licensed midwifery to the state’s Medicaid program. The cost-benefit analysis, released in 2008, reviewed the relevant published research literature and data from Washington and found that planned out-of-hospital births attended by Licensed Midwives in the United States and the State of Washington had rates of intrapartum and neonatal mortality similar to those of low-risk hospital births in the U.S. generally. Moreover, medical intervention rates for planned out-of-hospital births were significantly lower than those of planned low-risk hospital births. Using Medicaid claims data from Washington, the report concluded:

“The economic benefits of the midwifery program to the State of Washington far exceed the costs of operating the Program in estimating cost of deliveries, using the most conservative assumptions regarding c-section rates. These figures exclude prenatal care costs, newborn costs, and potential long-term costs related to morbidity.”

“The estimated cost savings for deliveries to Medicaid FFS in the most recent biennium is $488,147; about 1.8 times the cost of operating the state program which is $277,400.82. Cost savings to the health care system (Medicaid and private insurance) are much greater, about $2.7 million and this savings is close to 10 times the cost of operating the state program.”37,38

Data collected for a prospective cohort study of women receiving care in 79 midwifery-led birth centers in 33 US states from 2007 to 2010 included care provided by Certified Nurse-Midwives and Certified Professional Midwives. The study “demonstrated the safety of the midwifery-led birth center model of collaborative care as well as continued low obstetric intervention rates, similar to previous studies of birth center care. These findings are particularly remarkable in an era characterized by increases in obstetric intervention and cesarean birth nationwide.”39

A review of the benefits of midwife-led care more generally appears in the book *Optimal Care in Childbirth: The Case for a Physiologic Approach*. The authors explore how midwives, who are experts in the provision of physiologic care, can form the backbone of an integrated, woman-centered system that maximizes safety, efficiency, quality, and satisfaction.

**Professional Goals or Objectives Relative to Primary Maternity Care**

Certified Professional Midwives are primary maternity care providers. As described above, there are a few jurisdictions within which state Licensed Midwives also provide well-woman and/or family planning services. For example, midwives in Texas with documentation of additional education and training are allowed to assist with clients’ family planning needs. Midwives in Washington State have created specific mechanisms for expanding clinical procedures within the legal scope of midwifery practice. When the California Licensed Midwifery Practice Act was passed in 1993, the law mandated that direct-entry midwifery education programs are required to provide education and training in well-woman care and family planning. As a result, California student midwives complete extensive well-woman gynecologic and family planning education and training in order to obtain licensure from their regulatory authority, the Medical Board of California.

There is no discussion within the profession at this time regarding expanding the scope to include primary health care beyond these primary maternity care services.

**Comparative Educational Standards for Primary Maternity Care Practice**

Entry to the profession of midwifery is based on assessment of competency. Certified Professional Midwives may acquire the requisite knowledge and skills through a variety of pathways. A content analysis comparing the core competencies of the American College of Nurse-Midwives and the Midwives Alliance of North America showed nearly identical competencies for pregnancy, birth and postpartum care according to one author. She also found that the tools to assess skills and knowledge elaborated by the Accreditation Council for Graduate Medical Education were the same used in the evaluation process for Certified Professional Midwives. This is the only published work which compares the educational content standards for direct-entry midwifery and Certified Nurse-Midwifery. There are no published comparisons of the basic educational standards for midwives and physicians who provide primary maternity care in the United States. In 2009-2010, the International Confederation of Midwives completed two comprehensive studies involving surveys conducted in 90 countries. The purpose of

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the first study was to update the core competencies for basic midwifery practice, first delineated by the ICM in 2002, and the second was to develop global standards for midwifery education. The ICM adopted Global Standards for Midwifery Education in 2011.45,46,47

**Focused Education to Enhance Skills in Primary Maternity Care**

Certified Professional Midwives already provide primary maternity care and their training currently focuses on the critical knowledge and skills necessary to wellness promotion, preventative services, screening and referral as needed. Additional training to enhance skills in primary maternity care is provided through continuing education programs. As more states recognize the valuable role that CPMs can play in improving outcomes and reducing costs, it’s possible that they may be asked to take on expanded roles in well-woman health care.

**Barriers to a Greater Role in Primary Maternity Care Practice**

The major barriers to Certified Professional Midwives playing a more significant role in the provision of primary maternity care are the absence of state licensure in 24 states, limited third-party reimbursement, and opposition from conventional medicine. Nevertheless the number of CPMs is growing and the number of women choosing to give birth at home or in freestanding birth centers is increasing. Nationally, home birth rates rose 20% in the four year period 2004-2008.48 In Washington State, the home birth rate did not change significantly, but the percentage of births taking place in freestanding birth centers owned by Licensed Midwives increased by more than 50% between 2000 and 2009.49

State licensure and federal recognition are top priorities for the direct-entry midwifery profession and these will, in turn, open doors to Medicaid and other third-party reimbursement, employment in the public sector, funding for midwifery education, participation in scholarship and loan repayment programs, and so on.

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Re-thinking Primary Maternity Care

Certified Professional Midwives achieve excellent outcomes at lower cost because their care emphasizes healthy lifestyles, good nutrition, childbirth preparation, breastfeeding, counseling and support for the mother and family. Prenatal visits are typically 30 to 60 minutes long to allow time for client education, risk assessment, counseling and support. The midwife cares for the woman throughout her entire labor and birth. Home visits are made during the early postpartum period and follow-up continues for at least six weeks to monitor and support the successful establishment of breastfeeding and the transitions in family life. Women who give birth at home or in freestanding birth centers avoid unnecessary and expensive medical interventions and the facility fees associated with hospitalization. Fewer babies are compromised by prematurity, low birth weight and the effects of overused medical interventions, such as induction and cesarean section, which can lead to costly stays in neonatal intensive care units and future health challenges.

CPMs embrace the philosophy that pregnancy and childbirth are natural processes that require a focus on health as described by the Canadian Multidisciplinary Collaborative Primary Maternity Care Project. The care provided by CPMs takes the holistic, individualized, women-centered approach to service delivery, health promotion and the prevention and treatment of disease and illness which should be the hallmarks of a primary maternity care system.

Conclusion

The United States today does not have a system of primary maternity care. However, as health care costs escalate, national maternal-neonatal outcomes continue to deteriorate and public discontent with medicalized birth increases, policymakers and payers are searching for new, more effective models of care. A diverse set of stakeholders has been involved in a multi-year project, facilitated by Childbirth Connection, to articulate a vision for a high quality, high value maternity care system, create a blueprint for action, and support specific action steps being taken at the local, state and national level. The blueprint includes more than 40 major recommendations and specifically calls for expanding access to midwives with nationally-recognized credentials. Certified Professional Midwives are well-positioned and well-prepared to step into a larger role in the provision of primary maternity care.

51 Transforming Maternity Care Symposium Steering Committee. Blueprint for Action Steps Toward a High-Quality, High-Value Maternity Care System. Women’s Health Issues Volume 20, Issue 1, Supplement, Pages S18-S49 (January 2010).