Delivering Better Care:

Midwifery Practice in New Jersey

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NEW JERSEY HEALTH CARE QUALITY INSTITUTE

THE BURKE FOUNDATION

Executive Summary

With some of the worst maternal health outcomes in the nation, the need to deliver better care has never been more critical to the health and wellbeing of New Jersey communities. The midwifery model of care has been identified as a major lever of change for maternal health outcomes, yet this support remains inaccessible to the majority of those giving birth across the state, particularly those facing the highest risk of poor maternal health outcomes. The *Delivering Better Care: Midwifery Practice in New Jersey* report offers an entry point to unlocking the potential of midwifery practice by providing a detailed overview of the current state of midwifery in New Jersey and proposing state-specific recommendations for further exploration.

New Jersey ranks 47th in the United States for maternal health outcomes and is characterized by extraordinary racial disparities; a Black woman in New Jersey is seven times more likely to die than a white woman. As we look to improve these outcomes, midwives have been highlighted as key maternal health stakeholders in efforts to deliver better care through key initiatives such as the Nurture NJ initiative, launched by First Lady Tammy Murphy in 2019.[1] Through the Nurture NJ Strategic Plan, the state is pursuing action-driven, systemic change following an ecosystem roadmap where all birthing people are surrounded by environments that support their health and wellbeing.

Report Methodology

Over the course of 2021 and 2022, the Burke Foundation, in partnership with the New Jersey Health Care Quality Institute, undertook an in-depth review of the state of midwifery practice in New Jersey. This included analysis of available literature, interviews with experts, key stakeholders, and those working in the community and advocacy fields, as well as a convening of over 40 individuals practicing midwifery, working within the healthcare system, and supporting maternal care in the state of New Jersey. Through this extensive process, we worked to better understand the current state of practice for all types of midwives in New Jersey, opportunities to enhance and expand the important work of midwives, and strategies to better integrate midwifery into the maternal health workforce.

The Midwifery Model of Care

Midwives are clinical maternal health providers who work in partnership with birthing people, families, and communities to give necessary care throughout the lifespan.[2] The holistic, patient-centered midwifery model of care is associated with improvements in over 50 maternal and infant health outcomes, such as lower rates of mortality and morbidity, higher exclusive breastfeeding rates, and fewer unnecessary medical interventions.[3] The midwife scope of service extends beyond maternal care. Midwives work autonomously to provide care across the lifespan for women, including their annual preventative care needs and reproductive healthcare. Midwives also provide care for newborns during their first month of life.

While midwives are an essential part of the healthcare workforce, their work is often misunderstood, underutilized, and undervalued. Access to midwifery care and services remains extremely limited, particularly in communities of color that face the highest risk of poor maternal health outcomes, despite centuries of midwifery practice in North America. To address these issues and maximize the impact that midwives can have on health outcomes, the practice of midwifery must be better understood, streamlined, and integrated into the New Jersey maternal health landscape.

Midwifery in New Jersey

Today, New Jersey has 409 practicing midwives, including certified nurse-midwives (CNMs) (which make up over 90% of the state's midwifery workforce), certified midwives (CMs), and certified professional midwives (CPMs). As of 2019, less than 10% of all births in New Jersey were attended by midwives. These midwives practice in different settings in the state, such as private practice, hospital, and outpatient clinical settings. Midwives attend births and support pregnant people birthing in hospitals, freestanding birth centers, and in the home. Evidence also suggests that the midwifery model may help to reduce disparities by providing culturally congruent care — care that aligns with the language, values, beliefs, worldview, and practices of the patient.[4,5,6] Despite the clear benefits and scope of midwifery care, New Jersey's regulatory and administrative landscape, as well as a limited midwifery workforce, has resulted in significant barriers to accessing and having midwifery support during the perinatal period.

Key Findings and Proposed Areas for Further Exploration

This report highlights what we learned during our research, interviews, and stakeholder convening. Four key needs emerged throughout this work: (1) accessible and diverse education and training pathways; (2) equitable care provided within the midwifery scope of practice; (3) just compensation and reimbursement structures; and (4) improved quality outcomes through integration of midwifery care.

The following areas of focus highlight issues raised frequently during our interviews, research, and convening:

Midwifery scope of practice

New Jersey requires midwives to have a collaborative agreement with a physician. This creates unnecessary burden and limits practice autonomy for midwives.

Reimbursement issues

Medicaid covers roughly 40% of births in New Jersey and in this model, midwives are only reimbursed at 95% of the physician rate for providing the same services during the prenatal, birthing, and postpartum periods. Reimbursement for care in birth centers does not usually cover the actual cost of care provided, and there is currently no Medicaid coverage for midwife-attended home births. Additionally, many Medicaid Managed Care Organizations and commercial providers do not have birth centers as in-network or covered providers, limiting a pregnant person to midwife-attended births in the hospital.

Education and clinical training

While there are distance learning and fully virtual programs available for New Jersey students pursuing midwifery education, the only in-person midwifery degree program in the state is a Doctor of Nursing Practice (DNP) program at Rutgers University. For many students, the tuition and expenses for attending midwifery school are burdensome. The scarcity of midwife preceptors and integrated training opportunities within hospitals further limits the education pathways in the state.

Promoting racial and ethnic diversity in the midwifery workforce

Racism is embedded in the maternity care system in New Jersey and significantly contributes to the poor outcomes seen for pregnant and birthing people of color. According to the American Midwifery Certification Board (AMCB), most CNMs and CMs identify as white (86%) and women (99%) and speak English as their primary language (96%).[7] Approximately 7% of midwives identify as Black or African American, and only 5% of midwives identify as Hispanic or Latino. Racism also impacts the pipeline to the profession, with few midwives of color to recruit new students and serve as mentors.

Key recommendations and focus areas to strengthen, sustain and diversify midwifery practice in New Jersey include:

1. **Raise public awareness of the unique and important role that midwives play in the birthing sector**
2. **Reduce barriers to entry and retention in midwifery education**
3. **Diversify the midwifery workforce in New Jersey to address racial disparities and provide culturally congruent care that birthing people, especially from vulnerable populations, are seeking**
4. **Increase opportunities for midwife clinical training, including team-based and community-embedded training**
5. **Support systems-change efforts to increase insurance reimbursement rates for midwifery services and develop sustainable reimbursement models for midwifery care**
6. **Improve continuity of care with enhanced collaboration across New Jersey birth settings**
7. **Increase the opportunity for reimbursement for birth center births and home births**
8. **Support midwifery research and data collection through partnerships across universities, hospitals, and other entities**
9. **Drive policy change with New Jersey-based and national coalitions for midwifery care, specifically those focused on increasing practice autonomy for midwives in the state**

The findings in this report are a starting point to advance both the profession of midwifery in New Jersey as well as public awareness of and access to the services that midwives provide. It is essential that this work continues to advance the voices of midwives, maternal health advocates, academic, policy, and clinical experts who have been advocating for this profession for decades. Specifically, this includes prioritizing calls to diversify the profession and support midwives to reduce health inequities in the state by: supporting accessible and diverse education and training pathways, equitable care within the midwifery scope of practice, just compensation and reimbursement, and changes that improve outcomes, integration, and quality of midwifery care in New Jersey.

We recognize that not all people who become pregnant and give birth identify as women. While we use the gender-inclusive term "birthing people" as much as possible, we use "woman," "women," and "maternal" to conform with the language in externally published research findings.

About the New Jersey Health Care Quality Institute

The New Jersey Health Care Quality Institute (Quality Institute) is a multi-stakeholder non-profit organization that was founded in 1997. Our mission is to improve the safety, quality, and affordability of health care for everyone. To support healthy communities and individuals, we believe that health care should be: 1. Safe and of high quality; 2. Accessible and affordable; 3. Equitable, respecting individual dignity; and 4. Transparent, to promote accountability and quality improvement. For more than two decades, the Quality Institute has informed our research and policy work with the front-line experiences of our diverse membership of providers, purchasers, health plans, associations, consumer groups, and health care companies.

About the Burke Foundation

The Burke Foundation invests in transformative maternal and child health and early childhood initiatives to build a cycle of opportunity across generations in New Jersey and beyond. We fund transformative prenatal-to-early childhood initiatives in order to unlock the full potential of children and their communities. The Foundation was established in Princeton in 1989 by the late Jim E. Burke and his wife Diane ("Didi") Burke. During 37 years with Johnson & Johnson, Jim Burke built a legacy of visionary leadership, and served as Chairman and CEO for the last 13 years of his tenure.

Acknowledgements

The Quality Institute would like to acknowledge the staff, stakeholders, advocates, and experts who contributed to this report, greatly shaping the recommendations. A full list of contributors is available at the end of the document. Additionally, the Quality Institute thanks the Burke Foundation for their generous funding for the report and for their ongoing dedication and support for birth equity and advancing maternal infant health in New Jersey.

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Introduction: Midwifery Practice as a Pathway to Delivering Better Care

The United States has some of the worst maternal health outcomes of any developed country in the world.[8] In New Jersey, where alarming rates of maternal mortality and morbidity persist, outcomes are particularly dire for birthing individuals of color. As practitioners and policymakers examine approaches to address these preventable health outcomes, the perinatal health workforce has been recognized as a crucial lever to improve health and reduce disparities in outcomes. In 2021 and 2022, the Burke Foundation undertook research to explore the perinatal health workforce landscape in NJ - with a particular focus on midwifery - to better understand the current state, document promising practices/pathways, and share synthesized recommendations for further exploration and to better integrate and support midwifery as an essential part of the New Jersey birthing landscape.

In the most recent report available, the mortality rate in the United States was 17.4 deaths per 100,000 live births (2018 data), over twice as high as the rates seen in other high-income countries.[9] The U.S. had a C-section rate of over 30% as compared to 25% and lower seen in most European countries.[10] Although most poor maternal health outcomes are preventable, maternal mortality and morbidity incidents have been rising in vulnerable populations since the 1980s.[11]

Specifically, Black pregnant people in the United States are three times more likely to die than their white counterparts nationally, with wider variations at the state level.[12] In New Jersey, the racial disparity in maternal morbidity is even more stark. A Black woman in New Jersey is seven times more likely to experience a pregnancy-related death than their white counterparts.[13] Poor maternal health outcomes carry a significant social cost - causing loss of life and immeasurable trauma for the affected individuals, families, and communities - as well as a financial cost. According to the Commonwealth Fund, the projected cost of maternal morbidity, is $32.3 billion from the time of conception to the child's 5th birthday.[14]

Federal and state policymakers recognize the perinatal health workforce as a crucial lever to improve maternal health. Midwives play a powerful role in delivering improved outcomes, with compelling evidence demonstrating the positive impact of midwifery on maternal health, particularly among vulnerable populations. However, limited policy measures have been focused on midwives.

The person-centered holistic care provided by midwives "results in substantially higher rates of vaginal delivery and lower rates of C-sections, as well as significantly lower rates of preterm births and low-birthweight infants compared with other maternity models."[15] These outcomes are the result of the model of care used by midwives, which includes:

Monitoring the physical, psychological, and social well-being of the birthing person throughout the childbearing cycle

Providing the birthing person with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support

Minimizing technological interventions

Identifying and referring people who require obstetrical attention[16]

"Midwifery is an essential part of the solution as we work to improve maternal health outcomes here in New Jersey."

Beyond pregnancy, midwives provide a full range of primary care for women from adolescence through adulthood, including reproductive healthcare, family planning, and gynecologic services, as well as care during the postpartum period and care of the infant for the first month of life.[17]

Data shows that models of care employed by midwives are particularly effective in reducing racial disparities in maternal health outcomes due to strong historic ties to Black communities and its focus on providing culturally congruent care.[18] In New Jersey, where racial disparities in maternal health outcomes are extreme, midwives are an essential partner and potential catalyst in the state's effort to become a national leader in reducing adverse maternal and infant health outcomes.

This report details the current state of midwifery in New Jersey and proposes state-specific recommendations for further exploration. The contents are derived from an extensive literature review, policy analysis, interviews, and a multistakeholder convening with midwives and maternal health advocates conducted by the Burke Foundation and the New Jersey Health Care Quality Institute in 2021 and 2022. Throughout the report, the voices of birthing people and practicing midwives are quoted, adding context and clarity to our understanding of the profession and its impact on families and communities in New Jersey.

New Jersey's Maternal Health Context and Existing Initiatives

New Jersey ranks 47th in the United States for maternal health outcomes and is characterized by extraordinary racial disparities; a Black pregnant person in NJ is seven times more likely to die than a white pregnant person.[19]

To combat these racial disparities, promote equity in care, and reduce overall adverse maternal and infant health outcomes, First Lady Tammy Murphy launched the Nurture NJ initiative in 2019. Today, Nurture NJ's work remains rooted in action-driven, systemic change following an ecosystem roadmap where all birthing people are surrounded by environments that support their health and wellbeing.[20]

The three objectives underpinning Nurture NJ are to:

- Ensure all women are healthy and have access to care before pregnancy
- Ensure supportive community environments and contexts during every other period of a woman's life so that the conditions and opportunities for health are always available.[21]
- Build a safe, high-quality, equitable system of care and services for all women during prenatal, labor and delivery, and postpartum phases

Nurture NJ also presents a multi-pronged, multi-agency approach in its Strategic Plan to achieve its target objectives across nine action areas. The Strategic Plan highlights midwives as a key maternal health stakeholder. Four notable recommendations related to the maternal health workforce and midwives in the Nurture NJ Strategic Plan include:

RECOMMENDATION 4.3: which would "develop a communications plan to promote benefits of midwifery and community doula models of care"	**RECOMMENDATION 4.3.1:** "This campaign should be developed in collaboration with communities of color, building knowledge around the midwifery and community doula care models."
RECOMMENDATION 5.11: which seeks to "promote workforce development and retention in communities of color"	**RECOMMENDATION 5.11.1:** "The Department of Health should update existing regulations that allow only nurse midwives to attend hospital births, expanding to include certified midwives."
RECOMMENDATION 5.13 which would "support a representative, effective community workforce serving pregnant individuals and babies"	**RECOMMENDATION 5.13.1:** "The Department of Human Services should continue to improve Medicaid reimbursement for all obstetric providers to reach 100 percent of the physician rate, and require MCOs to reimburse for, and include all members of a perinatal care team (including doulas) in their networks."
	RECOMMENDATION 5.13.2: "The Department of Human Services should carefully review the results of the Center for Medicare and Medicaid Services Strong Start Evaluation for potential activities to expand access for Medicaid beneficiaries to the midwifery model of care."
	RECOMMENDATION 5.13.3: "The Department of Human Services should clarify that certified midwives are eligible to enroll as providers in the state Medicaid program."

RECOMMENDATION 7.4 which would "strengthen and expand the practice of midwifery model of care in New Jersey by building a more robust workforce pipeline"	**RECOMMENDATION 7.4.1:** "The Department of Health should work with state leaders to provide incentives to hospitals to serve as clinical sites for more student midwives and reimburse midwifery preceptors in hospital for training time."
	RECOMMENDATION 7.4.2: "Engage New Jersey's medical schools to implement interprofessional educational programs co-led by a midwife and OB-GYN physician team, like those in the Maternity Care Education and Practice Redesign, to encourage interprofessional collaboration."
	RECOMMENDATION 7.4.3: "One or more of the New Jersey state colleges should develop a midwifery program, not housed in a School of Nursing, modeled after the Jefferson College of Health Professions Midwifery Program, for individuals prepared at the bachelor's level who are not nurses and want to become midwives."
	RECOMMENDATION 7.4.4: "Diversify midwifery faculty through improved recruitment and removal of the requirement for a Master's in Nursing to become faculty in midwife training programs."
	RECOMMENDATION 7.4.5: "Require midwifery graduates who have received state funding for their education to practice in high need areas in New Jersey for two years after the completion of their training."[22]

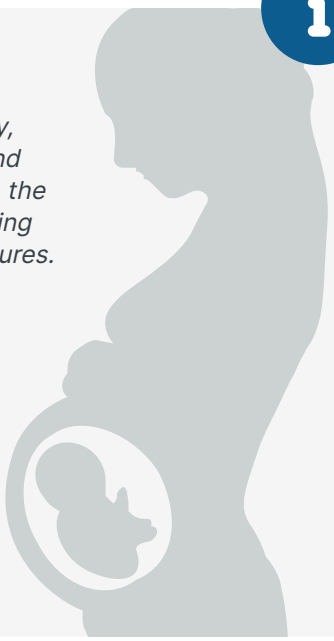
The Nurture NJ Strategic Plan also refers to positive health outcomes associated with midwifery care in New Jersey, noting that "the midwifery model of care is a patient-centered approach to pregnancy and birth that prioritizes education and empowerment of the woman."[23] Together, these recommendations can drive diversification and increased accessibility of midwifery services in New Jersey.

Despite Nurture NJ's recognition of midwives' potential to improve maternal health outcomes in New Jersey, midwives remain an overlooked, underutilized, and often undervalued resource in the state, regardless of the many midwives working actively to advocate for their field. To address this issue and maximize the role that these healthcare professionals can have on the health outcomes for all residents, the practice of midwifery must be better understood, streamlined, and integrated into the New Jersey birthing landscape.

We recognize that not all people who become pregnant and give birth identify as women. While we use the gender-inclusive term "birthing people" as much as possible, we use "woman," "women," and "maternal" to conform with the language in externally published research findings.

"Birth is a time I feel very vulnerable and really want to trust the people that are around me."

Roles and Types of Midwives



"*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 childcare.

A midwife may practice in any setting including the home, community, hospitals, clinics or health units."[24]

Source: International Confederation of Midwives
https://www.internationalmidwives.org/our-work/policy-and-practice/icm-definitions.html

Midwifery practice and licensure varies from state to state, and there can be significant confusion about the differences and similarities among the different types of midwives practicing in the United States.

Midwives can be classified into three categories: certified nurse midwives (CNMs), certified midwives (CMs), and certified professional midwives (CPMs). While New Jersey has midwives from each of these three categories practicing in the state, the majority of the midwives practicing in the U.S. and in New Jersey are Certified Nurse Midwives (see Table 1).

TABLE 1 **Midwifery Workforce in the U.S. and New Jersey**

	Midwifery Workforce	
	Nationally[25,26]	**New Jersey[27]**
Certified Nurse Midwives (CNMs)	12,218	376
Certified Midwives (CMs)	102	16
Certified Professional Midwives (CPMs)	2,750	17

To become a **Certified Nurse Midwife (CNM)**, an individual must have a degree in nursing and then complete a master's or doctoral degree in a program accredited by the Accreditation Commission for Midwifery Education (ACME), which takes a minimum of 24 months. They must then pass the national Certified Nurse Midwife exam administered by the American Midwifery Certification Board (AMCB) to become board certified.[28]

To become a **Certified Midwife (CM)**, an individual must have a bachelor's degree in a subject other than nursing and then complete a master's degree in midwifery in a program accredited by the ACME. They must also pass the national qualifying exam from the AMCB to become board certified.[29]

There are multiple pathways to become a **Certified Professional Midwife (CPM)**. The first option is to train through an apprenticeship with a qualified midwife, which refers to a midwife who has certification and experience as outlined under the North American Registry of Midwives (NARM), and then complete an Entry-Level Portfolio Evaluation Process (PEP), which is an educational evaluation process in which applicants' skills and knowledge are verified by qualified preceptors.[30] The second pathway is to attend a midwifery program or school accredited by the Midwifery Education Accreditation Council (MEAC), which may or may not confer a degree. Completion of either pathway qualifies applicants to sit for the NARM skills and written examinations to obtain Certified Professional Midwife status.[31]

TABLE 2 Overview of Education and Training Requirements of Midwives[32]

	Certified Nurse Midwives (CNMs)	Certified Midwives (CMs)	Certified Professional Midwives (CPMs)
Education	Graduate degree	Graduate degree	Certification does not require an academic degree and is based on demonstrated competency in specified areas of knowledge and skills.
Minimum Education Requirements for Admission to Midwifery Education Program	Prerequisites include bachelor's degree or higher from an accredited college or university AND Earn RN license prior to or within nurse midwifery education program.	Bachelor's Degree or higher from an accredited college or university AND Successful completion of required science and health courses and related health skills training prior to or within midwifery education program.	High School Diploma or equivalent Prerequisites for accredited programs vary and generally include specific courses such as statistics, microbiology, anatomy and physiology, and experience including childbirth education or doula certification. There are no specified requirements for the North American Registry of Midwives (NARM) Portfolio Evaluation Process (PEP) pathway. The Portfolio Evaluation Process (PEP) pathway is an apprenticeship process that includes verification of knowledge and skills by qualified preceptors. No degree is granted through the PEP pathway.
Clinical Experience Requirements	Knowledge, skills, and professional behaviors as identified by the American College of Nurse-Midwives (ACNM) Core Competencies for Basic Midwifery Education. Clinical education must be under the supervision of an American Midwifery Certification Board (AMCB)-certified CNM/CM or other qualified preceptor who holds a graduate degree, has preparation for clinical teaching, and has clinical expertise and didactic knowledge with the content taught. More than 50% of the formal clinical education must be under CNM/CM supervision. Clinical requirements must include hands-on patient experiences in different categories, including primary care, antepartum care, intrapartum management, birth, postpartum care, and gynecologic care.		Knowledge and skills, identified in the periodic job analysis conducted by NARM, are required. NARM also requires that the clinical component of the educational process must last at least two years and include a minimum of 55 births in three categories. Clinical education must occur under the supervision of a midwife who is nationally certified, legally recognized and who has practiced for at least three years and attended 50 out-of-hospital births post-certification. CPMs certified via the PEP may earn a Midwifery Bridge Certificate (MBC) to demonstrate they meet the International Confederation of Midwives (ICM) standards for minimum education.

Adapted from: ACNM Comparison of Certified Nurse-Midwives, Certified Midwives, Certified Professional Midwives Clarifying the Distinctions Among Professional Midwifery Credentials in the U.S. (July 2019). https://www.midwife.org/acnm/files/ccLibraryFiles/FILENAME/000000006807/FINAL-ComparisonChart-Oct2017.pdf

Midwifery Care: Quality and Outcomes

Perinatal patients supported by midwives consistently have some of the best maternal and infant health outcomes due to the holistic model of care and advocacy for the patient's needs. A collaborative report issued jointly by the United Nations Population Fund, the World Health Organization, and the International Confederation of Midwives in 2021 estimated that universal coverage of midwifery interventions would prevent 65% of maternal and infant deaths and stillbirths in low-and middle-income countries.[33] Research focused on high-income countries also shows significant benefits to patients in terms of satisfaction and outcomes, as well as cost savings to the healthcare system. Midwife-led continuity of care models, in which midwives support a woman throughout the perinatal period, have been shown to lead to increases in spontaneous vaginal births, as well as reductions in neonatal deaths and preterm births. Research has found these midwife-led models to be cost effective and associated with high levels of patient satisfaction.[34]

The midwife model of care is associated with more efficient resource usage: it is estimated that 90% of essential sexual, maternal, newborn, and reproductive services can be provided by midwives educated in accordance with international standards, licensed, and supported by interdisciplinary teams.[35] Research published in The Lancet identified more than 50 outcomes that could be improved by care within a midwife's scope of practice, such as reduced maternal and infant mortality and morbidity, fewer pregnancy-related interventions, increased uptake of contraception, improved psychosocial outcomes, and improved immunization rates for newborns.[36] In a study of over 23,000 planned births across 11 medical institutions, care provided by a CNM showed that the risk for C-section delivery for those who had never given birth before was 30% lower than care provided solely by an obstetrician. The same study showed that hospital stays were similar in length or shorter for midwifery-supported births.[37] Additionally, hospitals with midwifery care have a 75% lower rate of labor inductions and augmentation of labor. Midwifery care in the birth and postpartum period can also result in increased duration of breastfeeding, which has been associated with improved health outcomes for infants and birthing individuals.

A 2018 study found that individuals who had a midwife-attended birth were **three times as likely** to exclusively breastfeed less than six months postpartum and **six times more likely** to exclusively breastfeed at least six months compared to mothers with an obstetrician-attended birth.[38]

"I'm able to develop a relationship with my care provider. She really knows what's important to me and is 100% on my team."

"I feel so confident that if something did come up and I needed some help, I know she's there. She can help me and support me through it. She's equipped to deal with whatever comes up."

"I chose to pursue a hospital birth with a midwife. There were several benefits, including having the peace of mind that if something did happen, my care could be medically managed in the moment if needed."

While midwife integration in the United States has not been implemented and studied on a national scale, results from other countries and portions of the U.S. suggest that midwife integration may result in improved maternal health outcomes. Outside of the United States, midwifery-directed care is the standard for pregnant people. In the UK, France, and Australia, where maternal health outcomes are consistently better than the U.S., at least half of women's care is provided by a licensed midwife. In Finland, the default women's healthcare provider is a licensed midwife, with care transferred to an obstetrician only with an identified medical need.[39] Meanwhile, the most comprehensive study on midwife integration in the United States found that states that had higher midwife integration had better maternal outcomes.[40] In this study, midwife integration was measured by items such as scope of practice, autonomy, governance, and prescriptive authority; as well as restrictions that can affect patient safety, quality, and access to maternity providers across birth settings.

Evidence also suggests that the midwifery model of individualized, person-centered care may help to reduce disparities by providing culturally congruent care that improves outcomes for birthing people of color.[41,42] Midwives have historically aided the Black birth experience since the institution of enslavement in North America and have been recognized as respected community members.[43] However, the systemic marginalization of midwives of color has resulted in low midwife integration and low racial concordance between patients and the nurse midwifery workforce. This is historically rooted in the criminalization of Black "grand midwives" who provided care to the majority of pregnant people throughout the South until the professionalization of obstetrics and gynecology started in the 19th century.[44] As white men dominated the profession of obstetrics and profited off of the birthing experience, a narrative of midwives being untrained, unhygienic, and dangerous was widely perpetuated to the point that they were banned in many states, which eventually led to the government oversight and regulation of the profession that exists today.[45]

"My husband and I felt like we owned the birth space. My family members helped with my care and running the show during my hospital birth, and our midwife stepped back and let us do that."

The most comprehensive study on midwife integration in the United States found that midwife integration was lower in states with higher proportions of non-Hispanic Black populations, with adverse maternal health outcomes correlated with the racial composition of the population, and with low midwife integration.[46] While New Jersey shows a higher-than-average integration score, this is not reflected in the birth outcomes, particularly for Black birthing people in the state, indicating that there is still a need to focus on better integration.

Successful midwife integration and provision of culturally congruent care also requires intentional cultivation of a workforce that reflects the communities being served. The Commonwealth Fund notes that "in 2019, 49% of births in the U.S. were to people of color, but the nurse midwifery workforce remained 90% white. This reflects the historical exclusion and degeneration of the long tradition of Black midwifery in the U.S."[47] Sustained investment in diversifying and expanding midwifery pipelines is necessary to effectively address racial disparities in birth outcomes "as evidence suggests that racial concordance between provider and patient can improve satisfaction and quality of care."[48]

High-Risk Maternal Health Interventions in New Jersey Hospitals

The Leapfrog Group, a healthcare safety and quality watchdog organization,[49] conducts a Hospital Safety Survey and annual Maternity Care Report to measure and report hospital performance against best practices across three high-risk areas of maternity care: Nulliparous, Term, Singleton, Vertex (NTSV) cesarean sections (C-sections), episiotomies, and early elective deliveries. The report shows that too many hospitals across the country, and in New Jersey, are performing unnecessary interventions that can pose risks to the birthing person and infant. These are the very interventions where midwives have been shown to improve outcomes. C-sections can be necessary, but they also carry serious risks of infection or blood clots, longer recovery periods, and complications with future pregnancies. C-sections can also impact the health of babies, increasing the risk of NICU stays and the risk of development of chronic childhood diseases, such as asthma and diabetes.[50] Additionally, when a pregnancy is not allowed to progress to full-term (39 weeks) because of a scheduled, non-medically necessary, early elective delivery, the infant is at higher risk for several medical conditions, including longer hospital stay.[51] There is a crucial need to improve the quality of maternity care for all pregnant individuals, with special attention to those most at risk of death or harm. According to the March of Dimes, the rate of C-sections in Black women is higher than in women of other racial or ethnic groups.[52]

Table 3 highlights the recent Leapfrog maternity quality data from 2020, as compared to the recommended benchmark. Table 4 identifies additional quality measures that are available by county, indicating maternal and infant health outcomes based on geographic location in the state. Access to midwifery care during pregnancy and birth varies by county.

TABLE 3

2020 Leapfrog Group Data – Maternity Quality

(The Maternity Quality Measures data is taken from the 2021 Leapfrog Hospital Survey and covers one of two 12-month time periods - either Calendar Year 2019 or Calendar Year 2020.)

Hospital	Volume	Early Elective Rate </= 5% Leapfrog benchmark	NTSV C-Section Rate </= 23.6% Leapfrog benchmark	Episiotomy Rate </= 5% Leapfrog benchmark
Atlanticare Regional - Mainland	2074	0%	30.60%	3.20%
Cape Regional Medical Center	335	0%	28.40%	2.40%
Capital Health – Hopewell	3335	0%	18.60%	3%
Carepoint Health - Hoboken Univ	913	2.40%	32.80%	8.10%
CentraState Medical Ctr	597	0%	31.70%	8.50%
Chilton Medical Ctr	291	0%	22.10%	6.70%
Clara Maass Medical Ctr	1657	1.40%	25.30%	4.40%
Community Med Ctr	2077	0%	26.30%	4.10%
Cooper University Hospital	2100	0%	17.70%	1%
Englewood Hospital & Medical Ctr	2814	0%	20.90%	3.70%
Hackensack University Medical Ctr	5539	6.30%	25.20%	9.20%
HMH - JFK Medical Ctr	1788	0%	24.10%	18.50%
HMH - Mountainside Medical Ctr	854	3.50%	29%	7.30%
HMH - Palisades Medical Ctr	1021	0%	28.30%	3.70%
HMH - Pascack Valley Medical Ctr	1413	2.10%	22.70%	17.50%
Holy Name Medical Ctr	1512	8.90%	26.20%	16%
Hudson Regional Hospital	458	0%	35.8%	21.50%
Hunterdon Medical Ctr	982	0%	25.60%	2.70%
Inspira Medical Center Elmer	257	0%	20.20%	3.20%
Inspira Medical Center Mullica Hill	1110	2.60%	23%	3.40%
Inspira Medical Center Vineland	1632	0.60%	21.60%	1.20%
Jefferson Washington Township	906	0%	21.10%	3.60%
Jersey Shore University Medical Ctr	2931	0.60%	19.30%	6.50%
Monmouth Medical Center	5907	0%	20.10%	2%

Hospital	Volume	Early Elective Rate </= 5% Leapfrog benchmark	NTSV C-Section Rate </= 23.6% Leapfrog benchmark	Episiotomy Rate </= 5% Leapfrog benchmark
Morristown Medical Ctr	4978	0.30%	23.20%	7.30%
Newark Beth Israel Medical Ctr	2643	0%	23.50%	2.60%
Newton Medical Ctr	499	0%	16%	4.90%
Ocean Medical Ctr	830	0%	17.30%	3.30%
Overlook Medical Ctr	2357	0%	25.50%	5.10%
Penn Medicine Princeton Medical Ctr	2120	0%	33.50%	2.10%
Raritan Bay - Perth Amboy	957	1.90%	23.40%	5.90%
Riverview Medical Ctr	1281	6.20%	7.5%	3.10%
RWJUH New Brunswick	2482	0%	27.30%	2.80%
RWJUH Somerset	867	1.80%	23.60%	4.70%
Saint Barnabas Medical Ctr	6340	1%	28.90%	5.40%
Saint Clare's Hospital of Denville	1128	2.30%	33.80%	16.20%
Saint Peter's University Hospital	5192	2.20%	29.50%	8%
Shore Medical Ctr	910	0.00%	26.60%	9.40%
Southern Ocean Medical Ctr	334	5.40%	22.30%	7.50%
St. Joseph's University Medical Ctr	3281	0%	33.60%	8.60%
St. Mary's General Hospital	440	16.50%	34%	14.50%
The Valley Hospital	3521	2.50%	29.30%	11.20%
Trinitas Regional Medical Ctr	1144	0%	27.40%	2.70%
University Hospital	1218	0%	20.10%	1.70%
Virtua Memorial Hospital	2170	0%	21.90%	0.90%
Virtua Our Lady of Lourdes Hospital	741	0%	23.90%	2.50%
Virtua Voorhees Hospital	5498	0.50%	15.80%	0.90%

TABLE 4 County-Level Maternal Infant Health Outcomes[53]

County	% Preterm Singleton Births (<37 weeks)	NTSV C-Section Rate	Access to Care in the 1st Trimester
Atlantic	7.90%	29.00%	76.20%
Bergen	7.50%	28.30%	84.00%
Burlington	7.50%	22.60%	79.10%
Camden	8.30%	20.30%	70.60%
Cape May	6.80%	29.40%	74.00%
Cumberland	10.40%	18.90%	70.10%
Essex	9.00%	27.20%	65.60%
Gloucester	7.10%	21.10%	79.30%
Hudson	7.70%	29.80%	74.30%
Hunterdon	7.30%	26.30%	86.10%
Mercer	8.00%	24.60%	63.50%
Middlesex	7.50%	29.30%	77.60%
Monmouth	7.30%	25.00%	80.60%
Morris	6.60%	27.10%	84.60%
Ocean	5.40%	18.50%	74.70%
Passaic	9.40%	29.70%	71.90%
Salem	9.50%	29.10%	70.90%
Somerset	8.00%	27.10%	80.30%
Sussex	6.60%	26.80%	81.90%
Union	7.40%	26.80%	70.10%
Warren	6.80%	27.80%	82.20%

Midwifery Care: Cost Considerations

In addition to the benefits of improved quality and patient satisfaction, midwifery care has been shown to have the potential to lower overall costs of care for budget limited programs such as Medicaid. On average, the cost of childbirth for a low-risk pregnant person using midwife services was $2,262 less than births of this same low-risk demographic that used obstetrician care instead.[54] As described in the ***Midwifery Care: Quality and Outcomes*** section, models of care that include midwife services are likely to result in higher rates of vaginal births. In New Jersey, the average cost of a vaginal birth is around $14,000 per birth while the average cesarean birth costs almost $19,000.[55] A Medicaid-focused study of freestanding birth centers found that reimbursing for midwifery care at birthing centers could save an average of $1,163 per birth (2008 constant dollars), or $11.6 million per 10,000 births per year."[56] This could yield a lower total cost of care across Medicaid-covered deliveries. An analysis by the University of Minnesota School of Public Health found that increasing the percentage of midwife-attended births in the U.S. from the current rate of 8.9% to 15% could save over $1 billion by 2023. A further increase of 20% of births by 2027 could bring cost savings to $4 billion.[57]

> "On average, the cost of childbirth for a low-risk pregnant person using midwife services was **$2,262 less** than births of this same low-risk demographic that used obstetrician care instead"[51]

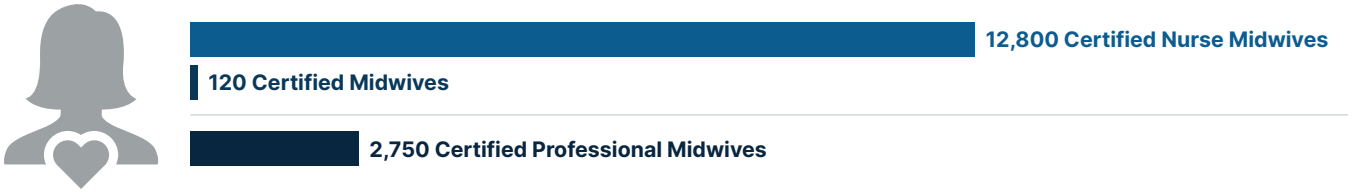
> "An analysis by the University of Minnesota School of Public Health found that increasing the percentage of midwife-attended births in the U.S. from the current rate of 8.9% to 15% could save over **$1 billion** by 2023. A further increase of 20% of births by 2027 could bring cost savings to **$4 billion**."[54]

Despite the evidentiary support for both the quality and cost-effectiveness of midwifery care, many payers have not implemented policy and payment changes that fully maximize these benefits. Without an explicit link between quality outcomes and maternal care payments, there may be limited incentive to adjust payment policies to incentivize and increase use of midwifery services.[58] For example, state Medicaid programs generally provide a lower midwife reimbursement rate than commercial payers despite evidence that midwifery involvement for low-risk births leads to an increased rate of vaginal deliveries and avoidance of episiotomies -- both of which are associated with lower costs of care. Medicaid covers 40% of New Jersey births. Increasing the reimbursement rate for midwifery services could benefit the state by improving maternal health outcomes and reducing Medicaid spending.[59]

In addition to increasing the reimbursement rate for midwifery care, there is also opportunity to explore value-based payments that promote quality. New Jersey FamilyCare, in alignment with supporting high-quality maternity care, launched the Perinatal Episode of Care in 2022.[60] The Episode of Care is voluntary for obstetric providers, including midwives, and makes providers eligible to receive episodic financial incentives based on achieving a minimum threshold for five quality benchmarks throughout the perinatal period, 280 days prior to delivery and 60 days postpartum. The Episode examines quality measures that span from prenatal care, delivery care, and postpartum follow-up for both the pregnant person and the infant. This example of a value-based payment model for Medicaid spending and reimbursement is in direct alignment with quality outcomes that are often highlighted in the midwifery model of care.

Midwives in the United States: Historical Practice and Demographic Profile

The number of midwives practicing in the United States varies significantly by the type of midwife and by demographic profile, with the need to expand the diversity of the profession. The American College of Nurse-Midwives reports that there are approximately 12,800 CNMs (nurses who have completed a graduate-level nurse-midwife program) and 120 CMs (non-nurses who have completed a graduate-level midwifery degree program) in the United States.[61] Similarly, the American Midwifery Certification Board 2020 Demographic Report, which collects licensure data on CNMs and CMs, found that 99.09% and 0.91% of midwives in the United States are CNMs and CMs respectively.[62] The National Association of Certified Professional Midwives reports that there are approximately 2,750 CPMs in the United States.[63]



CNMs and CMs attend 9-10% of all births nationally, with large variations across states, and less than 1% of all births in the United States are attended by other types of licensed midwives, including CPMs (for whom certification requirements do not require an academic degree, but is based on demonstrated competency).[64] In 2019, 8.95% of all births in New Jersey were attended by CNMs or CMs, and less than 0.2% of births in New Jersey were attended by "other" midwives, including CPMs.[65] Accurately capturing midwife attendance at births can be difficult though, due to limited data collection and public release of midwifery care data in New Jersey. According to stakeholders engaged in the report research process, hospitals where midwives do not have admitting privileges usually document vaginal deliveries under the collaborating/attending physician on the birth certificate. This may be one reason why there is incomplete data regarding midwife-attended births.

Currently, according to the American Midwifery Certification Board (AMCB), most CNMs and CMs identify as white (86%) and women (99%) and identify English as their primary language (96%).[66] Approximately 7% of midwives identify as Black or African American. Approximately 5% of midwives identify as Hispanic or Latino.[67] AMCB does not represent CPMs, so those professionals are not reflected in these demographics.

86%	7%	5%	99%	96%
White	Black or African American	Hispanic or Latino	Women	English as primary language

"We need to reach out to students, especially students of color, to let them know that midwifery is a viable career."

The lack of racial and ethnic diversity among midwives in the United States cannot be understood without closely examining the social history of American healthcare. Prior to the 19th century, midwives, particularly Black, indigenous, and immigrant midwives, were the primary providers of maternal care in the United States.[68] Among those enslaved and brought to the United States, some African women were skilled in maternal care, allowing them to attend births for other enslaved women as well as white women. Due to their expertise, traditional Black midwives were highly respected members of their communities, providing healing and spiritual care in addition to maternal care.[69]

By the early 20th century, the foundation of a new United States perinatal public health nursing workforce was effectively created through the Promotion of the Welfare and Hygiene of Maternity and Infancy Act known as the Sheppard-Towner Act. Designed to address high infant mortality rates in the United States, this federally funded effort included creating a workforce of white public health nurses and discouraged the use of traditional birthing methods in favor of a medical model of pregnancy and maternal care.[70] Though the Sheppard-Towner Act was short-lived and repealed several years after the initial passage, it had already shifted the model of midwifery care significantly toward more formal medical training. The American College of Nurse-Midwives, in an organizational Truth and Reconciliation resolution issued in 2021, noted that: "No coordinated effort was made to bring the apprentice-trained indigenous and Black midwives into this new workforce, and in many cases, they were actively excluded."[71] During this time, public health nurses introduced nurse-midwifery as a new specialty combining nursing and midwifery practice, with the first nurse-midwifery training programs beginning in the mid-1920s and early 1930s. The combined impact of the growth of nurse-midwifery and increased legislative action regulating traditional midwives contributed to the decline of traditional Black, indigenous, and immigrant midwives.[72] The legacy of this exclusion is still seen in many Southern states which have some of the most stringent midwifery regulations and some of the worst maternal health outcomes.[73]

New Jersey's Midwife Workforce

The number of midwife-supported births in New Jersey varies widely by county, based on the hospitals and birth centers where they practice and if they attend home deliveries. Table 5 outlines the number of CNM and other midwife births in New Jersey by county, for calendar year 2020.[74] These numbers can be considered against the national average rate of midwife-supported births, which is 4 per 1,000 live births.[75]

TABLE 5 **County Breakdown of Midwife-Supported Births - 2020**

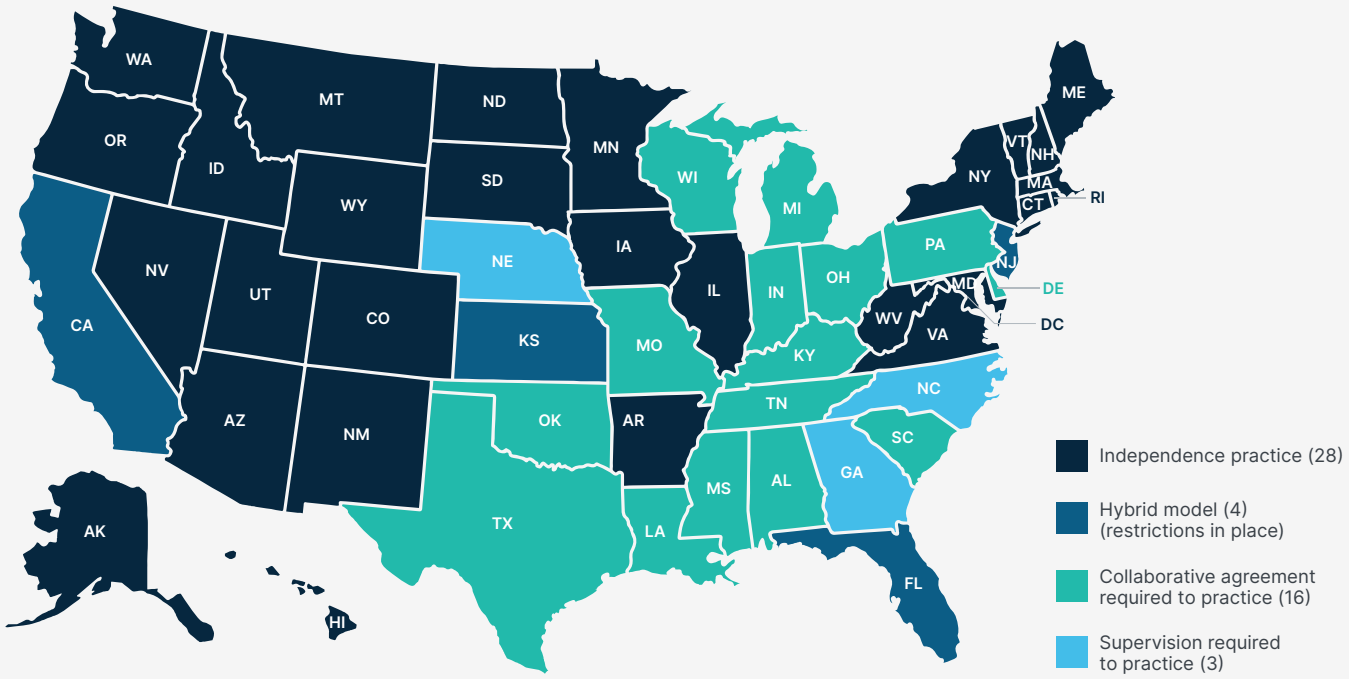
County	CNM	Other Midwife	Total Midwife Births	Total Births in County
Atlantic	961	4	965	2,760
Bergen	232	9	241	7,964
Burlington	621	9	630	4,153
Camden	791	10	801	5,416
Cape May	130	1	131	757
Cumberland	145	1	146	1,771
Essex	918	11	929	9,219
Gloucester	292	6	298	2,501
Hudson	189	8	197	7,810
Hunterdon	116	8	124	962
Mercer	1,395	3	1,398	3,848
Middlesex	262	6	268	8,301
Monmouth	137	21	158	5,544
Morris	216	6	222	4,564
Ocean	939	37	976	9,135
Passaic	504	5	509	6,133
Salem	43	0	43	525
Somerset	140	5	145	2,931
Sussex	83	5	88	1,237
Union	619	9	628	6,137
Warren	75	0	75	702

Data from the 2019-2020 New Jersey Board of Nursing (NJBON) license renewal survey, which included responses from over 112,000 New Jersey nurses, found that 91% of respondents identified as female and 49% were between the ages of 46-65. 58% of respondents identified as White/Caucasian, 13% as Asian, 8% as Black/African American, 5% as Hispanic, and 3% as Other.[76] As a point of comparison, 2019 US Census data for New Jersey overall indicates that 55% of residents identify as White (non-Hispanic), 10% identify as Asian, 15% identify as Black/African American, and 21% identify as Hispanic/Latino.[77] This suggests that Black and Hispanic/Latino populations are significantly underrepresented among New Jersey's nursing workforce, and that this trend is likely true for the midwifery profession in New Jersey as well. However, additional data would be needed to confirm demographics of midwives in the state.

Midwife Scope of Practice in New Jersey

The regulatory board for all types of licensed midwives in New Jersey (i.e., CNM, CM, and CPM) is the State Board of Medical Examiners in consultation with the Midwifery Liaison Committee (MLC).[78] The governor appoints the Board of Medical Examiners while MLC members are appointed through an application process. Midwifery advocates in New Jersey have raised concerns that the regulatory oversight framework for midwifery practice in New Jersey ultimately hinders women's access to midwifery care.[79] Any changes in midwife scope of practice (e.g., expanding practice authority for midwives) are under the purview of the Board of Medical Examiners. This regulatory arrangement in New Jersey is unusual, as most states (39 out of 50) regulate the practice of CNMs under their state Board of Nursing or a separate Board of Midwifery.[80]

FIGURE 1 **Practice Environments for Certified Nurse-Midwives**



Source: American College of Nurse Midwives
https://campaignforaction.org/wp-content/uploads/2021/01/certified-nurse-midwives-Practice-Environment-4-2021.pdf

Statutes and regulations define a midwife's scope of practice in New Jersey.[81] Many of New Jersey's current midwifery statutes date back to 1991, and while the state's midwifery regulations have been updated more recently, under New Jersey state statute, all midwives, including CNMs, must have a collaborative agreement with a physician in order to practice.[82]

This type of arrangement, generally speaking, is "the process whereby a CNM or CM who maintains primary management responsibility for the woman's care seeks the advice or opinion of a physician or another member of the health care team."[83] However, there is misalignment with the New Jersey Administrative Code for the Department of Human Services, which requires that any type of licensed midwife (i.e., CNM, CM or CPM) "shall

establish written clinical guidelines with the consulting physician which outlines the licensee's scope of practice."[84] This places an undue burden on the midwife to practice autonomously and to the full extent of their license.

The American College of Nurse-Midwives has issued a policy statement opposing requirements for signed collaborative agreements between physicians and CNMs/CMs "as a condition for licensure, reimbursement, clinical privileging and hospital credentialing, or prescriptive authority," on the grounds that there is no evidence that such requirements increase the safety or quality of patient care.[85] For example, the Joint Commission allows only licensed independent practitioners to admit patients to the hospital. In states where midwives practice in an arrangement that requires physician supervision, they can care for and attend hospital deliveries, but the primary signatory is considered the attending physician based on admitting privileges.[86]

Midwifery advocates in New Jersey have shared that the issue of full practice authority is of particular importance to midwives practicing across the state both to increase autonomy in practice and for the purpose of admitting and billing appropriately for care.[87] Additionally, research has found that states with regulations that support more autonomous midwifery practice have a larger midwifery workforce and a higher number of midwife-attended births. This research has also noted correlations between these autonomous practice laws and improved birth outcomes, including lower rates of cesarean deliveries, preterm births, and low birth weight infants.[88]

"Midwifery care should be the norm, not the niche."

Medical liability remains an issue regarding the collaborative agreement requirements for practicing CNMs and CMs. Mandating physician collaboration can be a barrier to midwifery practice. For example, some medical malpractice policies held by physicians impose a higher premium for those with collaborative practice agreements. Physicians may fear that their malpractice insurance premiums will rise if they enter into a collaborative agreement with another provider, and may consequently reduce the number of available practice opportunities for midwives.[89] Policies can also restrict safe and effective evidence-based birth practices, including vaginal birth after C-section, limiting the care able to be provided by the policyholder.[90] It is imperative for malpractice policies to align coverage with evidence-based practice standards to promote the best quality and safest care, rather than create incentives for defensive clinical practice.[91]

Currently, when working with a consulting physician, CNMs and CMs in New Jersey have a broad scope of practice which includes assessment, treatment and management of patients during the perinatal period, and well-woman care across the lifespan.[92] The midwifery scope of practice also includes providing primary care and preventative services, which can improve access to care in marginalized communities.[93] As noted above, CNMs practicing in New Jersey have prescriptive authority. CMs in New Jersey, however, currently do not possess prescriptive authority even though both CNMs and CMs receive the same pharmacology course, education, and training. In comparison, CPMs in New Jersey can practice in a healthcare system in consultation with a licensed physician; however, CPMs can only dispense or administer (but not prescribe) medications in accordance with written clinical guidelines.[94]

Most midwives who attend births in New Jersey practice in hospital-based settings. That said, all licensed midwives can provide legal out-of-hospital births for pregnant people in New Jersey.[95] In 2021, the state Department of Health issued guidance that expanded midwifery practice settings, enabling CPMs to practice in licensed freestanding birth centers in New Jersey in addition to attending births at home.[96] As part of the Affordable Care Act (ACA), states were mandated to cover free-standing birth center facility fees and the professional fees of the birth attendant.[97]

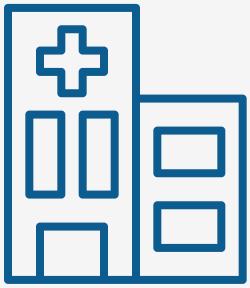
However, there are still significant limitations in midwife-supported births at home and in licensed freestanding birth centers related to reimbursement of services provided. For example, the facility fee for a Medicaid-covered fee-for-service birthing center birth is $1,300, which covers administrative, nursing, and technical services.

If the pregnant person requires transfer to a hospital for care, the rate is lowered to $500.[98] An additional barrier to midwife-supported births at licensed freestanding birthing center is inclusion of birthing centers within the Medicaid managed care networks.[99] Many participating Medicaid MCOs in New Jersey do not cover birthing center births, despite high quality outcomes associated with birth center deliveries, including a lower rate of C-sections, lower cost for both mother and infant over the following year ($2,100 in savings), and higher satisfaction from the birthing person.[100]

TABLE 6 **Average Cost of Birth by Setting in the United States[101]**

Setting of Birth	Average Cost
Hospital birth	$13,562*
Home birth	$4,650

*Includes the sum of all facility, professional, and newborn fees for vaginal hospital births, including payments by insurers and patients, for individuals with employer-provided insurance.



In the event of escalating care needs, birth centers will transfer the birthing person to a hospital for care.

Washington State has put in place the Smooth Transition program to create a system of coordinated and high-quality care across the care team at both locations. This process also governs the transition from a home birth to hospital, if necessary. Through facilitated seamless transfers, the Smooth Transition program has operated to bring new hospitals this framework of care and build collaborative partners with midwives working in birth centers and home births.[102]

There are very few freestanding, independent birth centers in New Jersey. As of February 2022, there were 4 freestanding birth centers in New Jersey (see Table 7 below). According to *The New York Times*, there were 400 freestanding birthing centers nationwide as of March 2021.[103] Independent freestanding birth centers face a host of challenges related to sustainability, including systemic challenges related to facility licensing, contracting, and inequitable payment models.[104] Additionally, stakeholders expressed a need for more birth centers that are owned and operated by people of color, as currently only 5% of birth centers in the United States are led by people of color.[105] The Birth Center of New Jersey in Union, New Jersey is the only birth center that is led by a Black clinical director in the state as of October 2021.[106]

"Bringing a child into the world is huge responsibility and one I don't take lightly. The fact that I can bring my child into the world in a calm, safe, secure, welcoming environment and not under hospital lights is just the most beautiful thing."

TABLE 7 Licensed Birth Centers in New Jersey

Name	County	Practice Model	Year Founded
Our Birthing Center *Morristown, NJ* https://www.ourbirthingcenter.com/	Morris	Clinical Director is a CNM, working with an OB-GYN physician. Clients receive prenatal care at other sites (of their choice) and then deliver at the center.	2018
The Birth Center of NJ *Union, NJ* http://birthcenternj.com/	Union	Clinical Director is a board-certified OB-GYN and a Black woman. Birth Center is staffed by CNMs, a CM, and doulas. Affiliated independent practices (listed on the Center's website) offer prenatal care. This list includes a practice entirely comprising CPMs.	2018
TRU Birth Center *Lakewood, NJ* https://www.trubirthcenter.com/	Ocean	Clinical Director is a board-certified OB-GYN, working with 6 CNMs.	2021
Virtua Midwifery Birth and Wellness Center *Voorhees, NJ* https://www.virtua.org/services/midwifery	Camden	Clinical Director is a CNM, working with 3 additional CNMs.	2021
Mary V. O'Shea Birth Center* *New Brunswick, NJ* https://www.saintpetershcs.com/Services/B/Birth-Center	Middlesex	Clinical Director is a CNM, working with 2 additional CNMs.	2019

** Not a freestanding birth center- part of St. Peter's University Hospital*

"We found a birth center that had midwives and felt like this was a great option because it had the safety of a hospital-like environment but could offer the kind of home birth experience that I wanted."

Midwife Education Opportunities in New Jersey

Many stakeholders interviewed emphasized the important role of educational programs in developing a diverse and well-trained workforce pipeline to the midwifery profession. In addition to distance-learning and in-person academic opportunities to train all types of midwives, stakeholders also raised concerns about student loan debt compared to salaries for midwives, availability of clinical placements, and the challenges associated with balancing course and field work along with other employment needed to bring in income and benefits while in school.

Currently, the Rutgers Nurse Midwifery Doctoral Nursing Program (DNP) is the only nurse midwifery education program in the state.[107] Admissions criteria include a minimum of a bachelor's degree in nursing from a nationally accredited program and a current RN license in New Jersey.

The program requires that students complete 81 course credits, a minimum of 810 clinical hours, and a minimum of 1,000 clinical practicum and DNP project experience hours (which includes clinical hours).[108] Rutgers' DNP program is ranked #15 out of 163 programs according to U.S. News and World Report and the University is consistently ranked one of the most diverse universities in the US in multiple rankings, including U.S. News and World Report.

Rutgers' DNP midwifery program offers both 4-year and 5-year program options, as of Fall 2021. Prior to this change, Rutgers offered a 3-year option and a 4-year part time option. For the 2021-2022 school year, tuition for New Jersey residents was $971 per credit, and $1,408 per credit for out-of-state students.[109] Including required fees, the overall cost for a New Jersey resident in the Rutgers DNP program is about $80,000 total, approximately $16,000-20,000 per year. As a point of comparison, nationally, the average nurse midwifery program annual tuition at public universities was $12,391 for in-state residents and $38,816 for out-of-state students for the 2020-2021 academic year.[110] Tuition rates can vary significantly based on whether the program is offered at a public or private institution.

Rutgers Nurse Midwifery Doctoral Nursing Program (DNP)

Program Details

4&5-yr
program options

$16-20K
approximate yearly cost

100%
pass rate for the American Midwifery Certification Board

Program Requirements

81
course credits

810
clinical hours

1,000
clinical practicum & DNP project experience hours (includes clinical hours)

In 2018, Rutgers' DNP program had a 100% pass rate for the American Midwifery Certification Board with no student needing retakes. A recent graduate of the Rutgers DNP program noted that her graduating class for 2021 comprised 14 students, over 75% of whom are students with diverse backgrounds and students of color.[111]

Interviews with stakeholders expressed differing opinions on the value of or need for a DNP program in order to practice clinically as a CNM. Some individuals reported that the field was moving towards the DNP degree as

being the standard education requirement for direct-entry midwifery practice as it contains valuable administrative, leadership, and research skills needed to thrive in the current healthcare environment.[112] Others felt that it required additional years of schooling and, in turn, student loan debt, for administrative and leadership training that may not be applicable to practicing clinicians and could be gained on the job in a professional environment or via certificate programs or coursework taken later in their career.

Stakeholders also raised the issue of student loan debt for graduating midwifery students. Students struggle to simultaneously manage demanding academic programs, working full- or part-time jobs to pay bills and have access to health insurance, and ensuring access to childcare while they are in class or clinicals. Multiple interviews noted that midwifery students are often told that they should not, or cannot, work while completing their degree due to the rigorous demands of the program. This presents significant barriers for low-income students entering the profession. Additionally, stakeholders referenced a lack of scholarships and loan forgiveness programs for midwifery students that are available to other healthcare professionals, which creates further financial barriers that can impact entry and completion of these academic programs.[113]

All midwifery programs, including the Rutgers DNP program, require clinical practicum hours supervised by licensed midwives practicing at hospitals and offices. Midwifery preceptors take on a great deal of responsibility and work related to supervising students,[114] often with limited institutional support and minimal compensation, especially as compared to physicians participating in medical student and residency training programs.[115] There are currently a number of clinical sites available to midwifery students in New Jersey who are enrolled in the Rutgers program, as well as those residing in the state and participating in a distance-learning nurse midwifery graduate program. However, it was reported in interviews with multiple stakeholders that clinical placement spots for midwifery students in New Jersey are very limited, that there is a great deal of competition across programs to gain placement, that privately funded universities may have access to endowment funds that can factor into which programs get placement spots. Additionally, clinical preceptors are not typically reimbursed for the significant time and resources spent when serving in this role, which can deter participation and result in even fewer placements for midwifery students.[116] In addition to a lack of clinical placement sites, better integrating the training model for CNMs and physician residents can shift the "one versus the other" paradigm often seen within the hospital setting and lead to better coordination of care.

At the University of California San Francisco (UCSF), interprofessional education has been a keystone of their training model for many years.

Through a Health Resources and Service Administration (HRSA) grant, UCSF has started the Interprofessional Care of Childbearing Families project, partnering midwife and physician training to promote teamwork and collaboration while increasing patient safety and quality. UCSF is also including co-taught courses for trainees in both fields to promote a better understanding of the evidence-based models used by both provider types.[117] This also helps teach future physicians about the physiologic birth model, to give practitioners a deeper understanding of normal birth progression.

"We need to attract and retain people who are passionate about being midwives and addressing the issues that face our birthing population."

While the Rutgers DNP program is currently the only nurse midwifery education program physically located in New Jersey, programs in nearby states and distance learning midwifery programs have become increasingly popular for students due to their educational flexibility. Most distance learning program curricula offer full- and part-time tracks and are centered around online coursework and clinical experience within the student's local community. According to U.S. News and World Report, the top-rated distance learning Master's in Nursing Programs offering Nursing Midwifery include George Washington University, Stony Brook University - SUNY, and University of Cincinnati.[118] Additionally, Frontier Nursing University's nurse-midwifery program was mentioned in different contexts by multiple interviewees as being a well-known midwifery education program. Midwives participating in distance learning nursing education programs offered by out-of-state schools could potentially do their clinical hours in New Jersey facilities; however, as mentioned earlier, it can be difficult to find clinical placements in the state.[119] There are also a multitude of midwifery programs in neighboring states that confer a master's degree and options for midwifery education to become a CNM. The Midwifery Institute at Thomas Jefferson University in Philadelphia is currently the only distance learning program offering CM training.[120] Additionally, the Advanced Certificate Program for Nurse Midwifery at Stony Brook University - SUNY is primarily distance learning with some on-site requirements.[121]

For those interested in becoming a CPM, there are 9 programs across the country that are accredited by the Midwifery Education Accreditation Council (MEAC).[122] While none of these programs are based in New Jersey, many of them offer distance-learning programs. For example, the Commonsense School of Midwifery offers three midwifery training programs, including a four-month Licensure by Endorsement program, which aims to prepare foreign-trained nurses or doctors, or midwives from other states as Florida Licensed Midwives. Midwifery students from MEAC accredited programs are eligible to sit for the North American Registry of Midwives (NARM) exam and subsequently practice as CPMs in their respective states.[123] Students seeking to become CPMs face the same barriers to clinical placements as other midwifery students in the state, which can be exacerbated by the small overall number of CPMs practicing in New Jersey.

Midwife Compensation and Reimbursement

The American Midwifery Certification Board 2019 Demographic Report states that over 80% of full-time nurse midwives make between $75,000-$149,000.[124] The U.S. Bureau of Labor Statistics found that New Jersey is one of the highest paying states for CNMs, with a mean salary of $121,050.[125] Salary.com reports a similar median salary benchmark ($124,222) for CNMs practicing in New Jersey.[126] Unfortunately, this high salary is offset by the cost of living in New Jersey, which has the third-highest median monthly housing cost in the U.S. and ranked 47th in the country in terms of purchasing power.[127,128] Additionally, and as indicated in Table 8, there are notable salary differences within the state, with CNMs practicing in southern New Jersey making approximately 15% less annually than their counterparts in northern New Jersey.[129]

TABLE 8 **Annual Midwifery Salary for Northern and Southern New Jersey**

Location	Annual mean salary for CNMs
New York-Newark-Jersey City, NY-NJ-PA (Northern, NJ)	$121,050
Philadelphia-Camden-Wilmington, PA-NJ-DE (Southern, NJ)	$102,680

There is limited data on CPM and CM salaries due to their relatively limited reach and varied restrictions across states. Presumably CM compensation is similar to CNM compensation, as their scope of practice is the same. Data is lacking on CPM compensation; however, most midwives who attend home births typically charge a flat rate between $3,000-$9,000 and may give cash discounts or payment plans.[130] A webpage created by New Jersey Homebirth Midwives during the COVID-19 pandemic refers to a "discounted rate" of $5,000 for homebirth services, also noting that there may be additional costs of $30-$80 depending on the type of supplies needed.[131]

"Home birth is not really something we can afford. It's something we save for, go into debt for, and have family help us out. But we make it work because it just so important for us."

"We need to ensure that there is equitable reimbursement for births in every setting so people insured by all insurers can access birth in the setting that they choose. "

Another component of midwife salary variance is the insurance reimbursement rate for their services. Medicare provides equitable reimbursement, paying CNMs at 100% the rate of physicians, as do most private insurance companies. The American College of Obstetrics and Gynecology (ACOG) recommends equal pay for midwives and physicians who are providing the same spectrum of services, in order to support midwives as an integrated part of the perinatal care continuum.[132] As a payer, Medicaid generally offers the lowest reimbursement rate of any payer for most services, including midwifery care.[133] 25 other states require Medicaid to reimburse midwives 100% of the physician rate for equitable services.[134] The Medicaid reimbursement rate for CNMs in New Jersey was recently increased, but is still only 95% of the rate that physicians are paid despite providing high-quality, patient-centered care that is equitable to physician-led care.[135] Currently, home births are covered by Medicaid in 21 states,[136] but they are still not fully covered by New Jersey Medicaid and are less likely to be covered by commercial insurance.[137]

While the recent increase in Medicaid reimbursement for midwifery care in New Jersey is beneficial, it is important to note that Medicaid reimbursement in general is much lower than reimbursement from private insurance. Specifically, commercial insurance payments for maternal and newborn care are about double the average Medicaid payment. In 2010, the average commercial payment for a vaginal birth was $18,239 compared to the average Medicaid payment of $9,131. Similarly, the average commercial payment for a cesarean birth was $27,866 compared to the average Medicaid payment of $13,590.[138]

Such reimbursement rates not only underpay midwives for work that is comparable or even better quality than obstetrician care, but it also limits pregnant people's access to equitable birth options, including birth centers and home births. For example, birth centers may choose not to accept Medicaid coverage because the low reimbursement rate does not cover the expense of providing care to both the delivering person and newborn, preventing patients with Medicaid coverage from accessing care through those centers.[139] While Medicaid faces budget constraints due to the nature of its joint federal and state government funding structure, a full consideration of costs would suggest that the cost of increasing midwifery reimbursement rates would likely be offset by cost savings associated with midwifery-led care, savings derived from a model of care that is associated with fewer medical interventions compared to obstetrician-led care.

Federal Midwife Policy Initiatives

In 2019, members of Congress introduced a record number of bills focused on birth equity, with some specific to midwifery. Although many did not move on to the next stage, several of these bills have been re-introduced in the current Congress. For now, most midwifery issues are contingent upon state-level licensure legislation and regulation; however, three major legislative packages and bills offer the promise for the first national midwifery policy.

The Midwives for Maximizing Optimal Maternity Services (Midwives for MOMS) Act seeks to address the U.S. maternity care shortage by expanding midwifery education access.[140] The bill establishes two new funding streams under Title VII and Title VIII that will primarily support student midwives pursuing both nursing and non-nursing tracks, expand or create midwifery programs, and increase preceptors at clinical training sites.[141] For these new grant programs, priority would be given to programs that increase diversity to address racial disparities that disproportionately impact Black and other pregnant people of color.[142] This bill did not pass in a previous congressional session but was recently reintroduced.[143]

The Perinatal Workforce Act seeks to establish grants for eligible education programs to diversify the perinatal workforce to address maternal health outcomes. Sections 2 and 5 specifically detail directives for diversifying and increasing access to midwifery education while reducing barriers to a midwife's full scope of practice.[144] The Perinatal Workforce Act is similar to the Midwives for MOMS Act in the effort to financially support historically marginalized and underrepresented groups within the maternal and infant health workforce. The Act is included in the Black Maternal Health Momnibus Act of 2021.[145]

The Black Maternal Health Momnibus Act of 2021 is a comprehensive approach to addressing Black maternal health that packages together 12 different pieces of legislation addressing the social determinants of health, access to care, and other aspects of racial and health equity.[146] It is the most comprehensive legislative package to combat maternal health racial disparities in the U.S. The Momnibus aims to invest in training a perinatal workforce to improve maternal health outcomes for Black and Brown communities. The main midwifery components of the Momnibus include (1) perinatal workforce guidance on best practices for respectful and culturally congruent maternity care, (2) a task force to analyze the licensing, training, and reimbursement for all midwives from racial and ethnic minority groups, and (3) grants for innovating data infrastructure to help maternal health providers track their patient health outcomes.[147]

Advocacy and Funding Context

Midwifery advocacy efforts in the United States are made possible through cross-functional partnerships and coalitions. Major advocacy groups range from domestic professional associations such as the American College of Nurse-Midwives (ACNM) as well as international groups like the International Confederation of Midwives (ICM). Some active advocacy groups work across a full range of midwifery models of care, such as the Midwives Alliance of North America (MANA) which "seeks to raise awareness and improve the quality, safety, equity, effectiveness and outcomes of maternal and child health care through the promotion of the Midwives Model of Care."[148] Others focus their advocacy efforts on specific types of midwives; for instance, the National Association of Certified Professional Midwives has built a toolkit specifically for CPM advocacy while also working collaboratively with other entities to strengthen midwifery in accordance with ICM's global vision.[149] While different organizations may have specific strategic priorities, they are all linked together by a common goal to reshape the U.S. midwifery landscape and improve maternal and child health outcomes. A list of these organizations is available in Table 9.

TABLE 9 **Midwifery Advocacy Organizations**

Organization Name	Priority Areas	Midwife Type (if applicable)	Geographic Focus	Website
Accreditation Commission for Midwifery Education	Advocacy, education	CNM and CM	National	https://www.midwife.org/accreditation
American Association of Birth Centers	Advocacy, policy	All midwives	National	https://www.birthcenters.org/
American College of Nurse-Midwives	Policy, advocacy, professional development	CNM, CM	National	https://www.midwife.org/
American College of Nurse-Midwives (NJ Affiliate)	Policy, advocacy, professional development	CNM, CM	New Jersey	https://newjerseymidwife.org/
Association of Midwifery Educators	Advocacy, education	All midwives	National	https://ame.clubexpress.com/content.aspx?page_id=22&club_id=297046&module_id=289340
Black Midwives Alliance	Policy, advocacy, professional development, mentorship, diversity	All midwives	National	https://blackmidwivesalliance.org/
Childbirth Connection	Advocacy, policy	All midwives	National	http://www.childbirthconnection.org/
Citizens for Midwifery	Advocacy, policy	CPM	National	https://www.citizensformidwifery.org/mission-index-impact
Coalition for Quality Maternity Care	Advocacy, policy	All midwives	National	https://nacpm.org/about-nacpm/coalitions-initiatives/cqmc/
Elephant Circle	Advocacy, diversity	All midwives	National	https://www.elephantcircle.net/
Foundation for the Advancement of Midwifery, Inc.	Advocacy, funding	All midwives	National	https://formidwifery.org/
Homebirth Summit	Advocacy, policy	CNM, CM, CPM	National	https://www.homebirthsummit.org/
Improving Birth Coalition	Advocacy	All midwives	National	http://www.motherfriendly.org/

Organization Name	Priority Areas	Midwife Type (if applicable)	Geographic Focus	Website
International Confederation of Midwives	Advocacy, policy	All midwives	Global	https://www.internationalmidwives.org/about-us/
Midwifery Education Accreditation Council	Advocacy, midwifery education	CPM	National	https://www.meacschools.org/
Midwives Alliance of North America	Advocacy, policy, research, education	CPM	National	https://mana.org/
National Aboriginal Council of Midwives	Policy, advocacy, professional development, mentorship, diversity	All midwives (focus on direct entry midwives)	Global (based in Canada)	https://indigenousmidwifery.ca/
National Association of Certified Professional Midwives	Policy, advocacy, professional development	CPM	National	https://nacpm.org/
National Association to Advance Black Birth	Policy, advocacy, professional development, mentorship, diversity	All midwives	National	https://thenaabb.org/
New Jersey Homebirth Midwives	Advocacy, policy	CPM	New Jersey	https://www.njhomebirthmidwives.com/
North American Registry of Midwives	Policy, advocacy, midwifery education and certification	CPM	National	https://narm.org/
The Big Push Campaign for Midwives	Advocacy, policy	CPM	National	https://www.pushformidwives.org/what_we_do
The Midwives and Mothers Action Campaign	Advocacy	CPM	National	https://static1.squarespace.com/static/5d27efdedf2122000134a532/t/615a0b794cdaeb4838df6fe1/1633291129977/https%3Awww.nacpm.org%3Awp-content%3Auploads%3A2017%3A10%3A3A-Federal-Recognition-History-Current-Strategy-of-the-MAMA-Campaign.pdf
US Midwifery Education, Regulation, and Association	Policy, advocacy, midwifery education	All midwives	National	http://www.usmera.org/

"I am in midwifery politics because I became a midwife. We advocate for the profession that people deserve."

A diverse group of funders has been instrumental in making both midwifery education and services more accessible in the U.S. Major pharmaceutical companies, such as Merck, have implemented programs like Safer Childbirth Cities that provide grants to improve maternal health infrastructure in urban environments.[150] Nonprofits like Every Mother Counts and the Foundation for the Advancement of Midwifery also provide crucial financial support to midwifery research and health equity initiatives. There are also prominent community-based funding arms such as the Birth Justice Fund whose mission is supporting organizations that connect pregnant people who may be low-income, people of color, and LGBTQ+ to midwifery services. A list of notable midwifery funding organizations is available in Table 10.

TABLE 10 Organizations Funding Midwifery Advancement

Organization Name	Priority Areas	Midwife Type (if applicable)	Geographic Focus	Website
Every Mother Counts	Policy, advocacy, funding, research	All midwives	Global	https://everymothercounts.org/our-approach/ https://nam.edu/publications/the-future-of-nursing-2020-2030/
The Birth Justice Fund	Funding	All midwives	National	https://groundswellfund.org/birth-justice-fund/
The Robert Wood Johnson Foundation	Funding	CNM	National	https://www.rwjf.org/en/our-focus-areas/topics/nurses-and-nursing.html
Johnson & Johnson	Funding	All midwives	Global	https://www.jnj.com/tag/midwives
Merck (Safer Childbirth Cities Initiative)	Funding	All midwives	National	http://www.saferchildbirthcities.com/
Yellow Chair Foundation	Funding, Policy	All midwives, with a focus on birth centers	National	N/A
New Jersey Birth Equity Funders Alliance	Funding	All midwives	New Jersey	https://birthequityalliance.com/
Midwifery Funders Group	Funding	All midwives	National	https://midwiferyfundersgroup.org/

Recommendations and Areas for Further Exploration

The Burke Foundation undertook this research project to better understand the landscape of midwifery in New Jersey, with an eye towards identifying potential areas of investment that might expand and diversify the practice of midwifery in New Jersey. During the research phase of this report, 16 interviews were held with midwifery stakeholders nationally and in New Jersey. In March 2022, the New Jersey Health Care Quality Institute and the Burke Foundation hosted a multi-stakeholder convening with representation from state and national policy experts in midwifery care, current practicing CNMs, CMs, and CPMs, representatives from various New Jersey state government departments, academia, patient representatives, community-based organizations and other prominent groups to discuss an initial draft of this report and build consensus around the next steps needed to advance midwifery in the state. In addition, the research team attended multiple webinars led by national midwifery experts,[151] and key themes from those sessions informed this research product. The research team collected qualitative feedback from midwives and midwifery stakeholders that illuminated a variety of barriers to midwifery practice and potential solutions. Table 11 below offers an overview of key themes identified during this process.

TABLE 11 **Overview of Key Themes – Midwifery Stakeholder Perspectives**

Midwifery Scope of Practice
• The regulatory framework for midwives in New Jersey is overseen by the Board of Medical Examiners. This arrangement is unusual and out-of-step with most other states, which instead allow Boards of Nursing to oversee midwifery practice or have separate Boards of Midwifery. This oversight framework may create unnecessary barriers to midwives practicing to the full extent of their training. • Private policies instituted by health systems create additional barriers for midwives to attain hospital admitting privileges. • There is widespread misunderstanding of midwifery scope of practice and educational preparation. • State requirements for a collaborative agreement with physicians present undue burden on midwifery practice without benefits to patients.
Lack of Data on Midwives and Births Outside of Hospital Settings
• There is a lack of high-quality data available in a wide variety of areas related to midwifery practice, including basic information about the number of midwife-attended births and demographics of midwives working in New Jersey. • There is a lack of publicly available outcomes data specific to midwifery in New Jersey.

Payment for Midwifery Care in New Jersey

- Maintaining comprehensive insurance coverage for community-based midwifery care is challenging. This makes it difficult for community-based midwives to follow their patients across settings and leads to payment gaps when a patient needs to be transferred to a hospital for care.
- Currently, claims submitted by a licensed healthcare facility for a facility fee with a midwife listed as the "attending provider" are often denied by Medicaid.
- New Jersey Medicaid reimburses midwives for 95% of the physician rate despite offering services and care that is equal.
- Payment models and regulatory requirements for freestanding independent birth centers are complicated, and it is extremely challenging to develop sustainable business models for these practices.
- New Jersey Medicaid reimbursement rates for birth center births are so low that most birth centers do not accept Medicaid.
- In most cases, New Jersey Medicaid does not cover midwifery services for home births.

Education and Clinical Training Opportunities

- Many stakeholders expressed equivocal, conflicted, or negative feelings about the fact that the only midwifery education program in New Jersey is a DNP program.
- Doctorate-prepared CNMs do not typically get compensated at a higher level than master's-prepared CNMs.
- The lack of midwifery preceptors is a barrier to creating a more robust midwifery workforce in New Jersey.
- Midwifery preceptors take on a great deal of responsibility and work related to supervising students. However, they are typically not compensated at all, or are undercompensated.
- There is a lack of parity between midwifery clinical opportunities and the opportunities available to medical residents in New Jersey.
- Health systems can access funding to offset the costs of medical resident training. Similar funding streams do not exist for midwifery.
- Midwives and medical residents would benefit from training together to build stronger and more integrated care teams.
- Multiple stakeholders expressed a desire to see a master's-level midwifery program in New Jersey, believing it would increase access to educational opportunities and support retention in the profession. Stakeholders noted that less time spent in school typically means less debt carried by the student.
- The cost of school is a barrier to entering the profession, and midwifery students may not have access to the same loan repayment programs or scholarships as other healthcare providers (e.g., physicians).
- A lack of knowledge about what midwives do is a barrier to entering the profession.

Promoting Racial and Ethnic Diversity Among Midwives

- Racism is embedded in the social history of nursing and midwifery in the United States.
- Economic considerations may prevent students from under-resourced backgrounds from beginning or maintaining engagement in a midwifery program.
- Highly motivated students of color may opt for medical school over a midwifery program for a variety of reasons, including a perceived lack of prestige and fewer career options for midwives.
- There is a lack of mentors for CNMs and CMs of color, which may negatively impact retention in the profession.

Key Recommendations to Strengthen Midwifery Practice in New Jersey

Key recommendations and areas for exploration from the interviews, convening, and research, especially as they relate to strengthening and diversifying midwifery practice in New Jersey, are reflected below. While some of these efforts will require investment from both public and private sectors and may take time to be implemented effectively, they are essential to advance the field of midwifery and achieve associated positive health outcomes for their patients.

At the time of publication of this report (Spring 2022), the New Jersey fiscal year 2023 budget had been introduced and was undergoing legislative review. Support for midwifery education and training was part of the proposed budget but had not yet been appropriated when this report was released.

Reduce barriers to entry and retention in midwifery education

1. Promote all available nurse midwifery programs, including master's level programs that are available virtually or through distance-learning to augment the program available at Rutgers
2. Explore opportunities to create or expand CPM educational programs
3. Create a community college MEAC accredited school with birth center attached for midwives to attend births and provide true community-centered care
4. Maintain part-time midwifery education options for prospective students
5. Spearhead a community engagement program to expose high school students and/or associate's-level nursing students to midwifery as a profession
6. Provide funding and support fellowships to individual midwifery students in New Jersey, including supports to assist students with childcare and health insurance while working towards licensure
7. Expand loan-forgiveness opportunities to midwifery students who choose to practice in different birth settings outside of the hospital (e.g., home births, birth centers, rural environments, etc.)

Diversify the midwifery workforce in New Jersey

1. Better understand the career progression and goals of community doulas and community health workers based on those currently working in these professions in New Jersey and as appropriate, create links and access to existing, new, or expanded midwife educational programs
2. Create or support a mentoring program and/or leadership development program specifically focused on aspiring midwives of color
3. Offer stipends to practicing clinicians of color to serve as mentors to nursing and midwifery students in New Jersey

Increase opportunities for midwife clinical training, including team-based and community-embedded training

1. Support the creation of interdisciplinary clinical training models that jointly educate midwives, physicians, and community health workers (e.g., ACOG-ACNM training framework[152])
2. Provide additional fiscal and institutional support for midwife clinical preceptors and midwife clinical training programs in New Jersey
3. Increase opportunities for clinical rotation placements for midwifery students, including in safety-net hospitals and free-standing birth centers
4. Promote hospital culture and training that educates staff and providers about midwifery practice as part of the care team

Support systems change efforts to increase insurance reimbursement rates for midwifery services and develop sustainable reimbursement models for midwifery care

1. Expand and increase insurance coverage for out-of-hospital midwifery services, including home births
2. Require Medicaid reimbursement of midwives at 100% of physician payment levels for the same service
3. Support business planning, billing support, and other technical assistance for freestanding birth centers led by midwives
4. Require Medicaid reimbursement of facility fees for all midwife-attended births at hospitals
5. Update Medicaid reimbursement rate of facility fees for birth centers and reimburse facility fee for newborn care at birth centers
6. Require New Jersey Medicaid Managed Care Organizations to expand their networks to include all New Jersey licensed birth centers and all licensed home birth providers in their provider networks

Support midwifery research and data collection through partnerships across universities, hospitals, and other entities

1. Collect data on the race, ethnicity, and practice location of midwives in New Jersey to better inform efforts to diversify the profession
2. Add midwifery tracking metrics to NJ Maternal Health Hospital Report Cards to measure midwifery outcomes and volume in hospital settings
3. Partner with research institutions in New Jersey to facilitate midwifery outcomes research in conjunction with state government and healthcare entities
4. Improve data infrastructure through updating NJ Maternal Data Center with more near-real-time data on midwife availability and outcomes in the state

Drive policy change with NJ-specific and national coalitions for midwifery care

1. Support the efforts of coalitions across the state to change midwifery policy (e.g., updating midwifery scope of practice regulations to enable full practice authority, and changing the statute to allow for plenary prescriptive privileges)
2. Support coalition-building among free-standing independent birth centers in New Jersey to build connections and activate networks to address unnecessarily burdensome facility regulations, especially through the support of birth centers owned and operated by people of color
3. Move oversight of all midwifery licensees to an independent Board of Midwifery
4. Create a public education campaign with the goal to inform all members of the public (i.e., consumers, healthcare workers, health administrators, politicians) about the benefits of the midwifery model of care

Improve continuity of care with enhanced collaboration across NJ birth settings

1. Ease transition across birth settings that allow midwives to remain connected to their patients (e.g., enabling homebirth patients to easily transition to hospital care due to unforeseen complications, similar to Washington's Smooth Transitions program[153])

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*The views, information, or opinions expressed during the convening are solely those of the individuals involved and do not necessarily represent those of the State of New Jersey.

Appendix A

Care Provided During Pregnancy and Delivery: The Role of the Obstetrician, Midwife, and Doula[154]

	Obstetrician	Midwife	Doula
Overview	An obstetrician, also known as an OB-GYN, is a medical doctor who has specialized training in reproductive and primary healthcare for women and pregnant people, including pregnancy, childbirth and disorders of the woman's reproductive system. They are also surgically trained to complete C-sections. OBs are focused on pregnancy and birth as a medical condition or event.	A midwife is a trained clinical health professional who supports healthy pregnant people during labor, delivery, and the postpartum period and can provide a full range of primary care for women from adolescence through adulthood, including reproductive healthcare, family planning, gynecologic services, and care of the infant for the first month of life. Midwives are focused on pregnancy and birth holistically, supporting a physiologic birth process to reduce or eliminate unnecessary interventions.	A doula is a trained non-clinical professional who offers physical, emotional, and educational support to pregnant people before, during, and after delivery. Doulas are not clinically trained and serve in a supportive role alongside care being provided by a medical doctor or midwife during the birthing process.
Training	Medical school degree and a minimum of 4 years of residency training that specializes in obstetrics and gynecology and surgical training to perform C-sections and other gynecologic surgeries. Board certification by the American Board of Obstetrics and Gynecology (ABOG).	Required education varies based on type of midwife, but the majority of midwives in the U.S. are CNMs and hold a graduate degree. CMs and CNMs are accredited by the American Midwifery Certification Board (AMCB). CPMs complete the NARM skills and written examination.	Successfully complete doula training program. Training requirements may vary by state based on whether the doula is reimbursed by an insurance carrier like Medicaid.[155]
Setting of Practice	Hospitals, birth centers, and homes	Hospitals, birth centers, and homes	Hospitals, birth centers, and homes

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