Evidence Based-Midwifery Regulation: Leveraging Law to Improve Equity, Access, and Outcomes

Maternal Infant Health Hub Policy Spotlight
May 3 2023
The New Jersey Healthcare Quality Institute & The Burke Foundation

Magda Schaler-Haynes, JD, MPH

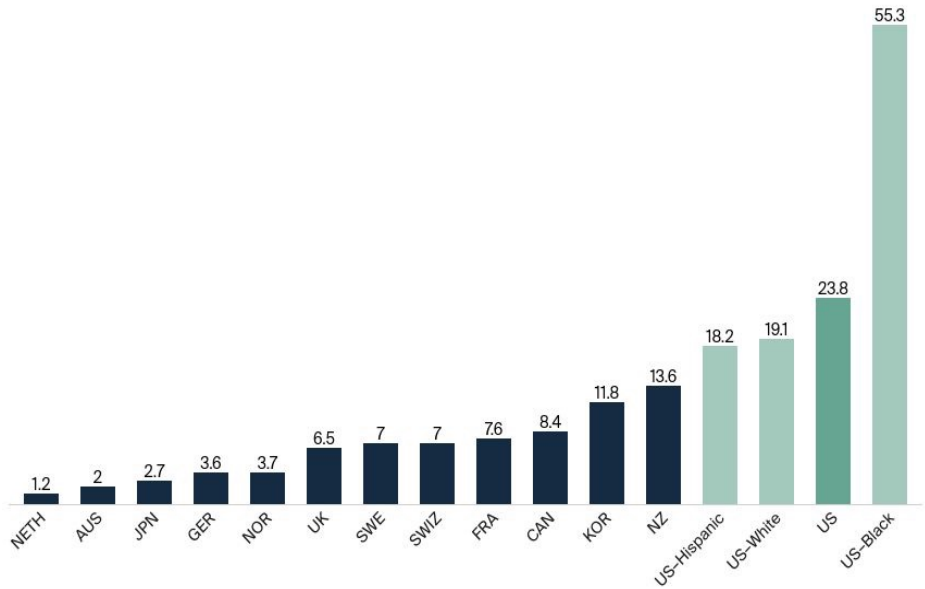
Department of Health Policy and Management

Mailman School of Public Health

Columbia University

New Data Shows U.S. Maternal Mortality Rate Exceeds That in Other High-Income Countries

Deaths per 100,000 live births



Download data

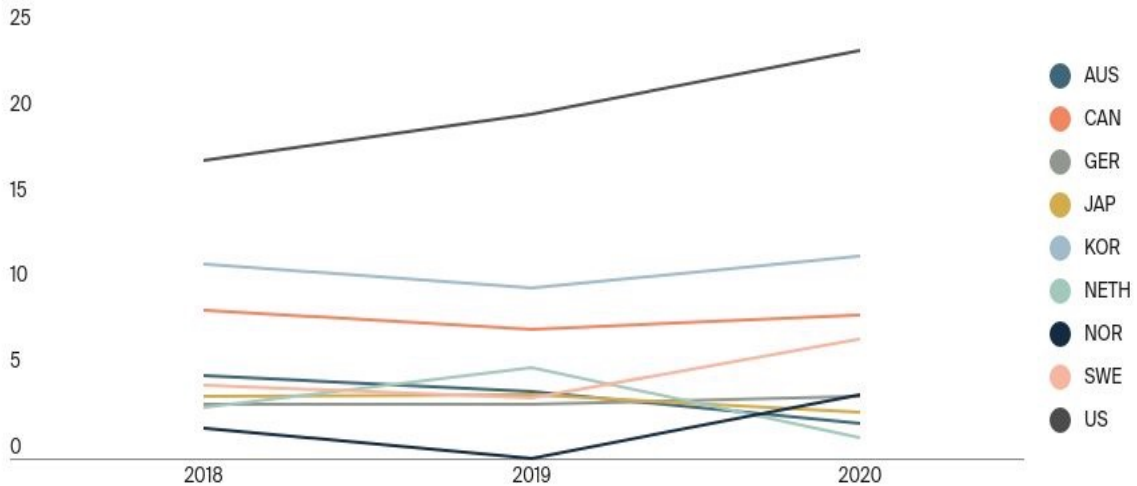
Notes: The maternal mortality ratio is defined by the World Health Organization as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. 2015 data for FRA; 2017 data for UK; 2018 data for NZ; 2019 data for SWIZ; 2020 data for AUS, CAN, GER, JAP, KOR, NETH, NOR, SWE, and US.

Data: Data for all countries except US from OECD Health Statistics 2022. Data for US from Donna L. Hoyert, *Maternal Mortality Rates in the United States, 2020* (National Center for Health Statistics, Feb. 2022).

Source: Munira Z. Gunja, Evan D. Gumas, and Reginald D. Williams II, "The U.S. Maternal Mortality Crisis Continues to Worsen: An International Comparison," To the Point (blog), Commonwealth Fund, Dec. 1, 2022. https://doi.org/10.26099/8vem-fc65

U.S. Maternal Mortality Rate Has Been Getting Worse over Time

Deaths per 100,000 live births



Notes: The maternal mortality ratio is defined by the World Health Organization as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

Data: Data for all countries except US from OECD Health Statistics 2022. Data for US from Donna L. Hoyert, *Maternal Mortality Rates in the United States, 2020* (National Center for Health Statistics, Feb. 2022).

Source: Munira Z. Gunja, Evan D. Gumas, and Reginald D. Williams II, "The U.S. Maternal Mortality Crisis Continues to Worsen: An International Comparison," To the Point (blog), Commonwealth Fund, Dec. 1, 2022. https://doi.org/10.26099/8vem-fc65

"…in the wake of slavery's end, skilled Black midwives represented both real competition for white men who sought to enter the practice of child delivery, and a threat to how obstetricians viewed themselves. Male gynecologists claimed midwifery was a degrading means of obstetrical care. They viewed themselves as elite members of a trained profession with tools such as forceps and other technologies, and the modern convenience of hospitals, which excluded Black and Indigenous women from practice within their institutions."

- Michele Goodwin, Chancellor's Professor of Law, University of California, Irvine

Goodwin, M. (July 2020). The Racist History of Abortion and Midwifery Bans, American Civil Liberties Union. https://www.aclu.org/news/racial-justice/the-racist-history-of-abortion-and-midwifery-bans/

"While widely accepted in Europe, midwives in the U.S. have been at the center of a long-running culture war that encompasses gender, race, class, economic competition, professional and personal autonomy, risk versus safety, and philosophical differences about birth itself."

Martin, N. (2018, Feb. 22) A Larger Role for Midwives Could Improve Deficient US Care for Mothers and Babies. *Propublica. https://www.propublica.org/article/midwives-study-maternal-neonatal-care*

“Historically, Black women’s voices and talents have been pushed aside or regulated out of modern medicine. The expertise of Black midwives is a prime example of the way that Black women caring for one another in childbirth has been erased by modern medicine and replaced by the incorrect notion that Black women do not value midwifery or understand prenatal care. The facts are that Black women brought the tradition of midwifery with them to the United States and doctored one another through centuries of enslavement, Jim Crow, and segregation.”

Black Mamas Matter Alliance, Setting the Standard for Holistic Care of and for Black Women, Black Paper April 2018. https://blackmamasmatter.org/wp-content/uploads/2018/04/BMMA_BlackPaper_April-2018.pdf

Defining Structural Racism

"A system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity. It identifies dimensions of our history and culture that have allowed privileges associated with "whiteness" and disadvantages associated with "color" to endure and adapt over time. Structural racism is not something that a few people or institutions choose to practice. Instead it has been a feature of the social, economic and political systems in which we all exist."

*The Aspen Institute Roundtable on Community Change "*Glossary for Understanding the Dismantling Structural Racism/Promoting Racial Equity Analysis"

https://www.aspeninstitute.org/wp-content/uploads/files/content/docs/rcc/RCC-Structural-Racism-Glossary.pdf

Potential Benefits of Midwifery Care

- Reduce unnecessary C-section
- Increase spontaneous birth
- Reduce episiotomies
- Reduce use of forceps
- Reduce overuse of medical technologies
- Reduce pre-term birth
- Reduce health disparities
- Increase patient centered care delivery
- Increase patient satisfaction and outcomes
- Yield cost savings to the healthcare system
- Improve access to family planning
- Increase rates of breastfeeding and its related benefits

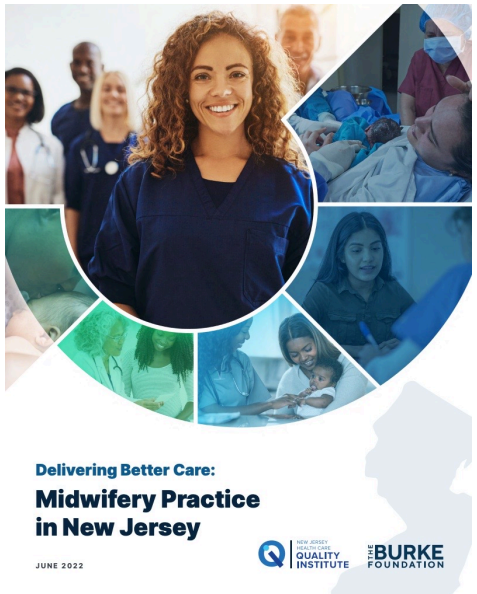
Renfrew MJ, McFadden A, Bastos MH, et al. Midwifery and quality care: Findings from a new evidence-informed framework for maternal and newborn care. *Lancet*. 2014;384(9948):1129-1145.

Homer CS, Friberg IK, Dias MA, et al. The projected effect of scaling up midwifery. *Lancet*. 2014;384(9948):1146-1157.

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



Source:

The New Jersey Healthcare Quality Institute and The Burke Foundation. Delivering Better Care: Midwifery Practice in New Jersey (June 2022)

“It is important to understand at the outset […] that midwifery and obstetrics are two distinct professions- with different philosophies and overlapping but distinct bodies of knowledge. Midwives are not practicing from the middle realm of obstetrics. They are practicing midwifery.”

Judith Pence Rooks *Midwifery and Childbirth in America.* Temple University Press. 1997. P. 6

Midwifery in New Jersey and New York neighboring, divergent statutory definitions

N.J.S.A. 45:10-1 defines the practice of midwifery thus: “a person shall be regarded as practicing midwifery within the meaning of this chapter who attends a woman in childbirth as a midwife, or advertises as such, by signs, printed cards or otherwise” (NJ)
https://lis.njleg.state.nj.us/nxt/gateway.dll?f=templates&fn=default.htm&vid=Publish:10.1048/Enu

§6951 Definition of practice of midwifery (NY)

1. The practice of the profession of midwifery is defined as the management of normal pregnancies, child birth and postpartum care as well as primary preventive reproductive health care of essentially healthy women, and shall include newborn evaluation, resuscitation and referral for infants. A midwife shall have collaborative relationships with (i) a licensed physician who is board certified as an obstetrician-gynecologist by a national certifying body or (ii) a licensed physician who practices obstetrics and has obstetric privileges at a general hospital licensed under article twenty-eight of the public health law or (iii) a hospital, licensed under article twenty-eight of the public health law, that provides obstetrics through a licensed physician having obstetrical privileges at such institution, that provide for consultation, collaborative management and referral to address the health status and risks of his or her patients and that include plans for emergency medical gynecological and/or obstetrical coverage. A midwife shall maintain documentation of such collaborative relationships and shall make information about such collaborative relationships available to his or her patients. Failure to comply with the requirements found in this subdivision shall be subject to professional misconduct provisions as set forth in article one hundred thirty of this title.
2. A licensed midwife shall have the authority, as necessary, and limited to the practice of midwifery, to prescribe and administer drugs, immunizing agents, diagnostic tests and devices, and to order laboratory tests, as established by the board in accordance with the commissioner's regulations. A midwife shall obtain a certificate from the department upon successfully completing a program including a pharmacology component, or its equivalent, as established by the commissioner's regulations prior to prescribing under this section.

- Any reference to midwifery, midwife, certified nurse-midwifery or certified nurse-midwife, nurse-midwifery or nurse-midwife under the provisions of this article, this chapter or any other law, shall refer to and include the profession of midwifery and a licensed midwife, unless the context clearly requires otherwise.

https://www.op.nysed.gov/professions/midwifery/laws-rules-regulations/article-140#:~:text=%C2%A76951%20Definition%20of%20practice%20of%20midwifery.&text=A%20midwife%20shall%20maintain%20documentation,to%20his%20or%20her%20patients.

New Jersey Midwifery Liaison Committee of the Board of Medical Examiners ("Board")

The Midwifery Liaison Committee shall consist of eight members who shall serve as consultants to the Board [of Medical Examiners] and who shall be appointed by the Board.

The Committee shall include at least one certified nurse midwife, at least one certified professional midwife, at least one certified midwife, and two other midwives, all of whom shall hold licensure from the Board.

The Committee shall also include one certified nurse midwife who is a member of the Board and two physicians, one of whom shall be a member of the Board of Medical Examiners and one of whom shall be Board-certified by either the American Board of Obstetrics and Gynecology, the American Osteopathic Board of Obstetrics and Gynecology or any other certification organization with comparable standards. The Board shall appoint each member for a term of three years. Committee members may be reappointed.

Functions of the Committee shall include the following:

1) Advising and assisting the Board in the evaluation of applicants for midwifery licensure and certified nurse midwife applicants for prescriptive authorization; 2) Investigating complaints against licensees and unlawful conduct by licensees; 3) Approving professional education programs; and 4) Advising and assisting the Board in drafting and reviewing rules to govern midwifery practice.

[…]

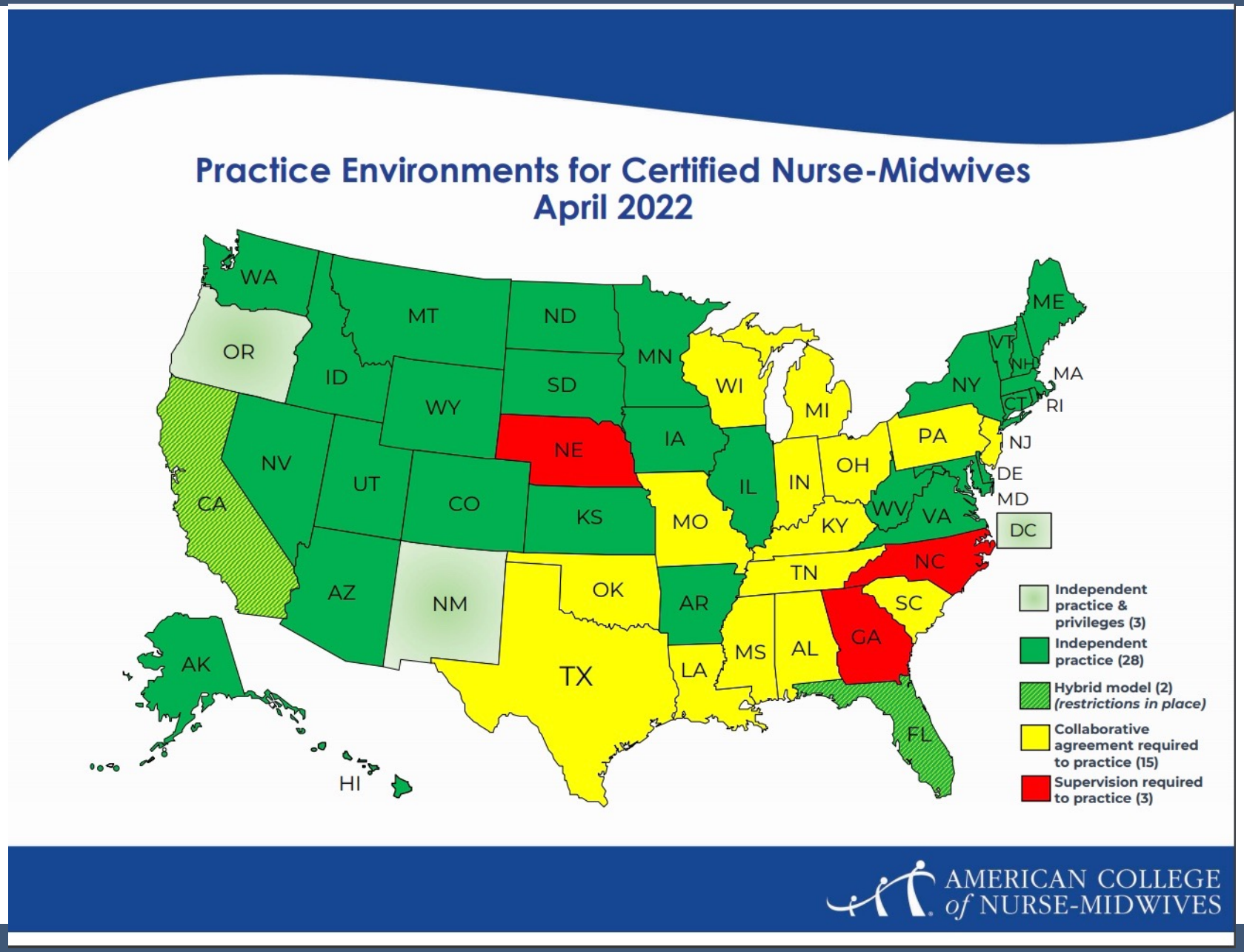
https://www.njconsumeraffairs.gov/regulations/Chapter-35-Subchapter-2A-Midwifery-Liaison-Committee.pdf

New York Midwifery Board

§6954 State board of midwifery

1. The state board of midwifery shall be appointed by the board of regents on recommendation of the commissioner for the purpose of assisting the board of regents on matters of professional licensing and professional conduct in accordance with section sixty-five hundred eight of this title. The board shall be composed of thirteen individuals. Initial appointments to the board shall be such that the terms shall be staggered. However, no members shall serve more than two terms.
2.
    a.
        1. Seven members of the board shall be persons licensed or exempt under this section.
        2. One member of the board shall be an educator of midwifery.
    b. Two members of the board shall be individuals who are licensed physicians who are also certified as obstetrician/gynecologists by a national certifying body.
    c. One member of the board shall be an individual licensed as a physician who practices family medicine including obstetrics.
    d. One member of the board shall be an individual licensed as a physician who practices pediatrics.
    e. One member of the board shall be an individual not possessing either licensure or training in medicine, midwifery, pharmacology or nursing and shall represent the public at large.
3. For purposes of this article, "board" means the state board of midwifery created under this section unless the context clearly indicates otherwise.

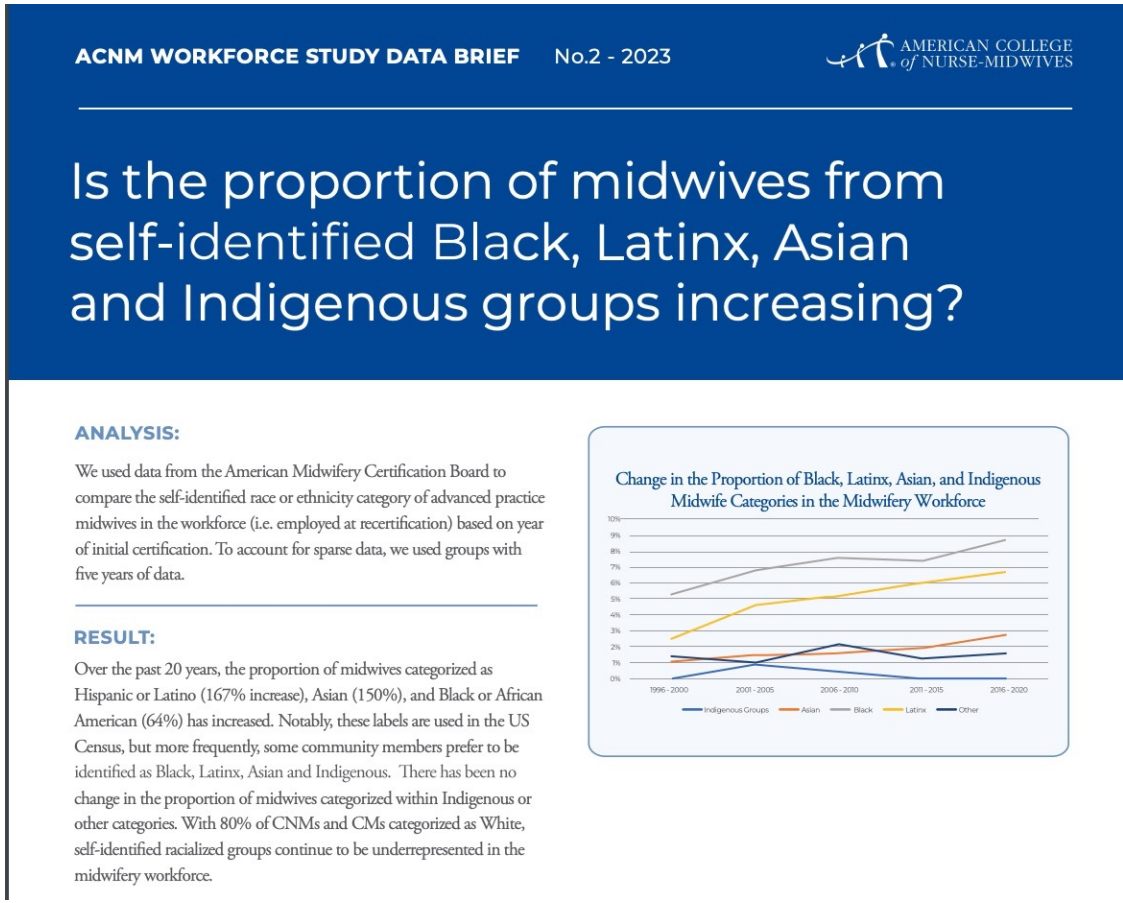
https://www.op.nysed.gov/professions/midwifery/laws-rules-regulations/article-140#:~:text=%C2%A76951%20Definition%20of%20practice%20of%20midwifery.&text=A%20midwife%20shall%20maintain%20documentation,to%20his%20or%20her%20patients



https://www.midwife.org/acnm/files/cclibraryfiles/filename/000000008515/Practice%20Environments%20for%20Certified%20Nurse-Midwives%20(April%202022).pdf

- “in 2019, 49% of births in the US 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.”

Zephyrin, L. et al (2021, Mar 4). Community-Based Models to Improve Maternal Health Outcomes and Promote Health Equity. Commonwealth Fund



ACNM WORKFORCE STUDY DATA BRIEF No.2 - 2023

AMERICAN COLLEGE of NURSE-MIDWIVES

Is the proportion of midwives from self-identified Black, Latinx, Asian and Indigenous groups increasing?

ANALYSIS:

We used data from the American Midwifery Certification Board to compare the self-identified race or ethnicity category of advanced practice midwives in the workforce (i.e. employed at recertification) based on year of initial certification. To account for sparse data, we used groups with five years of data.

RESULT:

Over the past 20 years, the proportion of midwives categorized as Hispanic or Latino (167% increase), Asian (150%), and Black or African American (64%) has increased. Notably, these labels are used in the US Census, but more frequently, some community members prefer to be identified as Black, Latinx, Asian and Indigenous. There has been no change in the proportion of midwives categorized within Indigenous or other categories. With 80% of CNMs and CMs categorized as White, self-identified racialized groups continue to be underrepresented in the midwifery workforce.

Change in the Proportion of Black, Latinx, Asian, and Indigenous Midwife Categories in the Midwifery Workforce

For Consideration: Potential Features of Modernized Midwifery Landscape

- Independent Midwifery Board (e.g. New York)
- Full Practice Authority: Removal of formal collaboration agreement with a physician
- Clinical practice guidelines for physician collaboration, consultation and referral retained
- Privileges in Birthing Hospitals and Birth Centers
- Transition plans in place for home birth (e.g. Washington State's Smooth Transitions)
- Malpractice insurance requirement
- Prescriptive authority for CMs on par with CNMs
- Potential license fee increase due to administrative costs associated with establishment of new, independent board and board staff
- Modification to birth certificates to indicate "intended" place of birth and improved data collection re birth attendants
- Public safety assured by continued requirements for:
  - Education, training and examination including implicit bias training
  - Discipline and enforcement functions retained by the Board
- Invest in scholarships for midwifery training and education to expand provider supply
- Others?

Expected benefits of a Modernized Midwifery Structure

- Increased access to midwifery care
- Heightened focus on patient needs
- Increased midwifery workforce
- Reduced costs
- Opportunity for inclusive process (stakeholder-driven)
- Improved maternal health outcomes resulting from increased access to midwifery care
- Increased appeal of midwifery practice in New Jersey (attract midwives from other states)

The Federal Trade Commission's analytic framework asks a number of key questions relevant to our discussion today, including:

- "Will the regulation significantly impede competition by, for example, making it more costly or difficult for the regulated group of professionals to enter into competition, or expand their practices, or by otherwise increasing the cost of health care services or reducing their availability?
- Are there any significant and non-speculative consumer health and safety needs that particular regulatory restrictions, extant or proposed, are supposed to meet?
- Do those particular regulations actually provide the intended benefits – such as improvements in health care outcomes or a reduced risk of harm from poor-quality services – or are there good grounds to think they are likely to provide those benefits?
- Are there other demonstrated or reasonably likely consumer benefits associated with the proposed regulation (e.g., reduced information or transaction costs for consumers who are choosing among providers, reduced consumer confusion in distinguishing among different types of providers, etc.)?
- When consumer benefits are slight, insubstantial, or highly speculative, a regulation that imposes non-trivial impediments to competition is not justified.
- If pertinent consumer harms have occurred, or risks are found to be substantial, is the proposed regulation likely to redress those harms or risks?
- Are the regulations narrowly tailored to serve the state's policy priorities? When particular regulatory restrictions address well-founded consumer protection concerns but – at the same time – appear likely to harm competition, consider whether the regulations are narrowly tailored to address those concerns without undue harm to competition, or whether less restrictive alternatives are available."

Source: https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf (internal citations omitted)

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Office of Policy Planning
Bureau of Competition
Bureau of Economics

July 25, 2016

Director, Regulations Management (02REG)
Department of Veterans Affairs
810 Vermont Avenue, NW
Room 1068
Washington, DC 20420

Re: RIN 2900–AP44-Advanced Practice Registered Nurses

The staffs of the Federal Trade Commission Office of Policy Planning, Bureau of Economics, and Bureau of Competition ("FTC staff") [1] appreciate the opportunity to respond to your request for comments on the Department of Veterans Affairs' (the "Department" or the "VA") proposed rule, "Advanced Practice Registered Nurses" ("Proposed Rule").[2] For reasons explained below, FTC staff support the Department's initiative to maximize its staff capabilities. Our prior examination of the impact of nursing regulations on health care competition reinforce the VA's view that the Proposed Rule would:

- increase the Veterans Health Administration's ("VHA") ability to provide timely, efficient, and effective primary care services, among others; and
- increase veteran access to needed health care, particularly in medically underserved areas, as well as decrease the amount of time veterans spend waiting for patient appointments.[3]

These changes in VA policy may also benefit health care consumers in private markets.

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Office of Policy Planning
Bureau of Competition
Bureau of Economics

January 09, 2020

The Honorable Thomas E. Brinkman, Jr.
Ohio House of Representatives
77 S. High St, 11th Floor
Columbus, OH 43215

Dear Representative Brinkman:

The Federal Trade Commission ("FTC" or "Commission") Office of Policy Planning appreciates the opportunity to respond to your request for comments on House Bill 177 ("H.B. 177" or "the Bill"), a proposal to expand the scope of practice of Advanced Practice Registered Nurses ("APRNs") in Ohio.[1] In particular, you asked for our input on the Bill's proposal to "end the mandatory written collaborative agreement requirement."[2] For reasons explained below, we urge the Ohio legislature to adopt that proposal and rescind the collaborative agreement requirement.

VA | U.S. Department of Veterans Affairs

News Release

Office of Public Affairs
Media Relations

Washington, DC 20420
(202) 461-7600
www.va.gov

FOR IMMEDIATE RELEASE
Dec. 14, 2016

VA Grants Full Practice Authority to Advanced Practice Registered Nurses

Decision Follows Federal Register Notice That Netted More Than 200,000 Comments

WASHINGTON - The Department of Veterans Affairs (VA) today announced that it is amending provider regulations to permit full practice authority to three roles of VA advanced practice registered nurses (APRN) to practice to the full extent of their education, training, and certification, regardless of State restrictions that limit such full practice authority, except for applicable State restrictions on the authority to prescribe and administer controlled substances, when such APRNs are acting within the scope of their VA employment.

"Advanced practice registered nurses are valuable members of VA's health care system," said VA Under Secretary for Health Dr. David J. Shulkin. "Amending this regulation increases our capacity to provide timely, efficient, effective and safe primary care, aids VA in making the most efficient use of APRN staff capabilities, and provides a degree of much needed experience to alleviate the current access challenges that are affecting VA."

VA Final Rule
Advanced Practice Registered Nurses (2016)

The Final Rule specifies

“ A CNM has full practice authority to provide a range of primary health care services to women, including gynecologic care, family planning services, preconception care (care that women veterans receive before becoming pregnant, including reducing the risk of birth defects and other problems such as the treatment of diabetes and high blood pressure), prenatal and postpartum care, childbirth, and care of a newborn, and treating the partner of their female patients for sexually transmitted disease and reproductive health, if the partner is also enrolled in the VA healthcare system or is not required to enroll.”

81 FR 90198 https://www.federalregister.gov/documents/2016/12/14/2016-29950/advanced-practice-registered-nurses

Selected Organizational Statements

ACOG/ ACNM: "ACOG's Joint Statement of Policy with the American College of Nurse-Midwives supports full scope, autonomous practice for certified nurse-midwives (CNMs) and certified midwives (CMs) and birth center accreditation and licensure" https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2018/joint-statement-of-practice-relations-between-ob-gyns-and-cnms

Black Mamas Matter Alliance: "Historically, Black women's voices and talents have been pushed aside or regulated out of modern medicine. The expertise of Black midwives is a prime example of the way that Black women caring for one another in childbirth has been erased by modern medicine and replaced by the incorrect notion that Black women do not value midwifery or understand prenatal care. The facts are that Black women brought the tradition of midwifery with them to the United States and doctored one another through centuries of enslavement, Jim Crow, and segregation." (Black Mamas Matter Alliance, Setting the Standard for Holistic Care of and for Black Women, Black Paper April 2018. https://blackmamasmatter.org/wp-content/uploads/2018/04/BMMA_BlackPaper_April-2018.pdf

The March of Dimes: "March of Dimes encourages states to examine their laws and regulations related to midwifery care to ensure they are not unnecessarily restrictive, foster access to these services for women who desire them and promote full practice authority for midwives as part of an integrated system of care."
https://www.midwife.org/acnm/files/cclibraryfiles/filename/000000008056/MARCH%20OF%20DIMES%20midwifery%20position%20statement%20August%2029%202019.pdf

Center for American Progress: Eliminating Racial Disparities in Maternal and Infant Mortality A Comprehensive Policy Blueprint "Collaborative agreements hamper access to midwifery care when a midwife cannot identify a physician willing to sign the agreement. This can be cause for denial of payment, even if the services provided are within the midwife's scope. The requirement of a formal agreement with a physician can also limit the availability of midwives in a particular state or hospital, leading to limitations on opportunities to practice midwifery as well as access to midwifery care for women and families in need. Similarly, the lack of authority to prescribe also imposes challenges for midwives as the requirement prevents them from building independent practices..."
(Taylor et al, 2019, internal citations omitted)
https://www.americanprogress.org/article/eliminating-racial-disparities-maternal-infant-mortality/

Additional References and Resources (non-exhaustive)

See slides above for in-slide citations

Advancing New Standards in Reproductive Health (ANSIRH), Implications of Catholic Hospitals on Reproductive Health Care: Women Want to Know Issue Brief, August 2021 https://www.ansirh.org/sites/default/files/2021-08/Women%20on%20Catholic%20Healthcare%20081221.pdf

Cartwright AF, Bullington BW, Arora KS, Swartz JJ. Prevalence and County-Level Distribution of Births in Catholic Hospitals in the US in 2020. *JAMA.* 2023;329(11):937–939. doi:10.1001/jama.2023.0488

Eugene R. Declercq et al., State Regulation, Payment Policies, and Nurse-Midwife Services, 17 Health Affairs 190 (1998)

Goodwin, M. (July 2020). The Racist History of Abortion and Midwifery Bans, American Civil Liberties Union. https://www.aclu.org/news/racial-justice/the-racist-history-of-abortion-and-midwifery-bans/ https://www.aclu.org/news/racial-justice/the-racist-history-of-abortion-and-midwifery-bans

M. Hatem et al., Midwife-led Versus Other Models of Care for Childbearing Women, 4 Cochrane Database of Systematic Reviews CD004667 (2008);

Homer CS, Friberg IK, Dias MA, et al. The projected effect of scaling up midwifery. *Lancet*. 2014;384(9948):1146-1157.

Kennedy et al United States Model Midwifery Legislation and Regulation: Development of a Consensus Document JMidwiferyWomensHealth2018;63:652–659c 2018bytheAmericanCollegeofNurse-Midwives.

Additional References and Resources (non-exhaustive)

National Academies of Sciences, Engineering, and Medicine. 2021. *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity*. Washington, DC: The National Academies Press. https://doi.org/10.17226/25982.

Renfrew, M.J., McFadden, A., Bastos, M.H., Campbell, J., Channon, A.A., Cheung, N.F., et al. (2014). Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care. The Lancet, 384 (9948), 1129–45. doi: 10.1016/S0140-6736(14)60789-3.

Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews 2016, Issue 4. Art. No.: CD004667. DOI: 10.1002/14651858.CD004667.pub5

Wascher JM, Hebert LE, Freedman LR, Stulberg DB. Do women know whether their hospital is Catholic? results from a national survey. *Contraception*. 2018;98(6):498-503. doi:10.1016/j.contraception.2018.05.017: