NEW JERSEY'S REGULATORY AND LICENSING STRUCTURE:

Approaches for Modernizing the Midwifery Profession

New Jersey Health Care Quality Institute
Maternal Infant Health (MIH) Hub Midwifery Convening
April 25, 2024

Magda Schaler-Haynes, JD, MPH
Department of Health Policy and Management

COLUMBIA | MAILMAN SCHOOL OF PUBLIC HEALTH

Overview

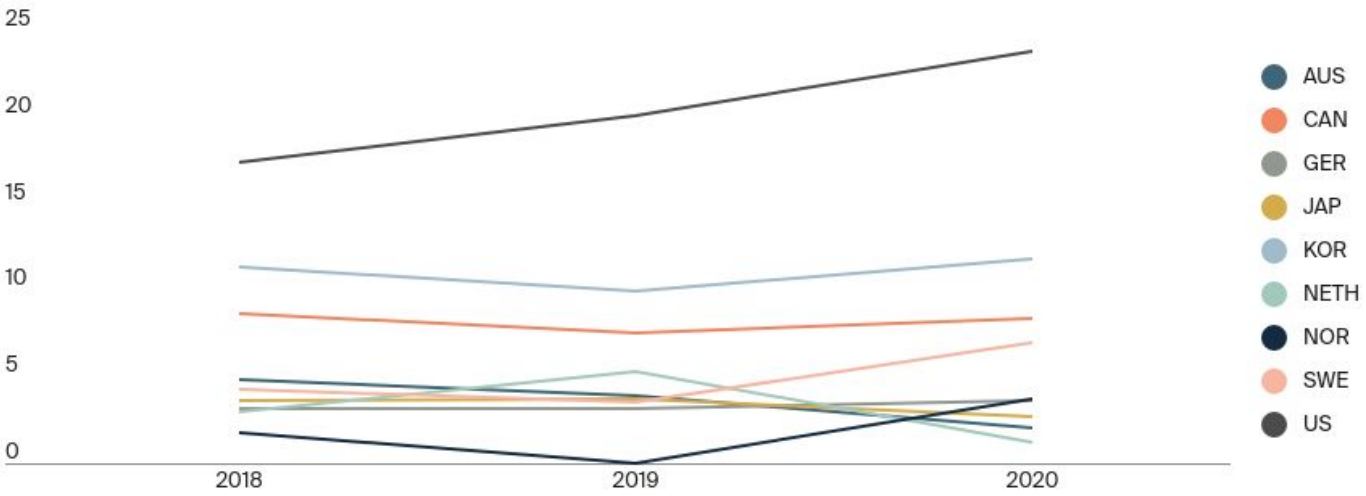
1. Licensing and Regulation in New Jersey
2. Elements and Impact of an Independent Board and Autonomous Practice of Midwifery
3. Changes Needed to Achieve Modernization
4. Considerations Relevant to New Jersey's Midwifery Landscape
5. Financial Considerations for New Jersey Midwives
6. Discussion/ Q & A

Acknowledgements

- The New Jersey Maternal Infant Health (MIH) Hub Advisory Board
- MIH Hub's Midwifery Collaborative
- The New Jersey Midwifery Liaison Committee

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

Introduction: Landscape Overview

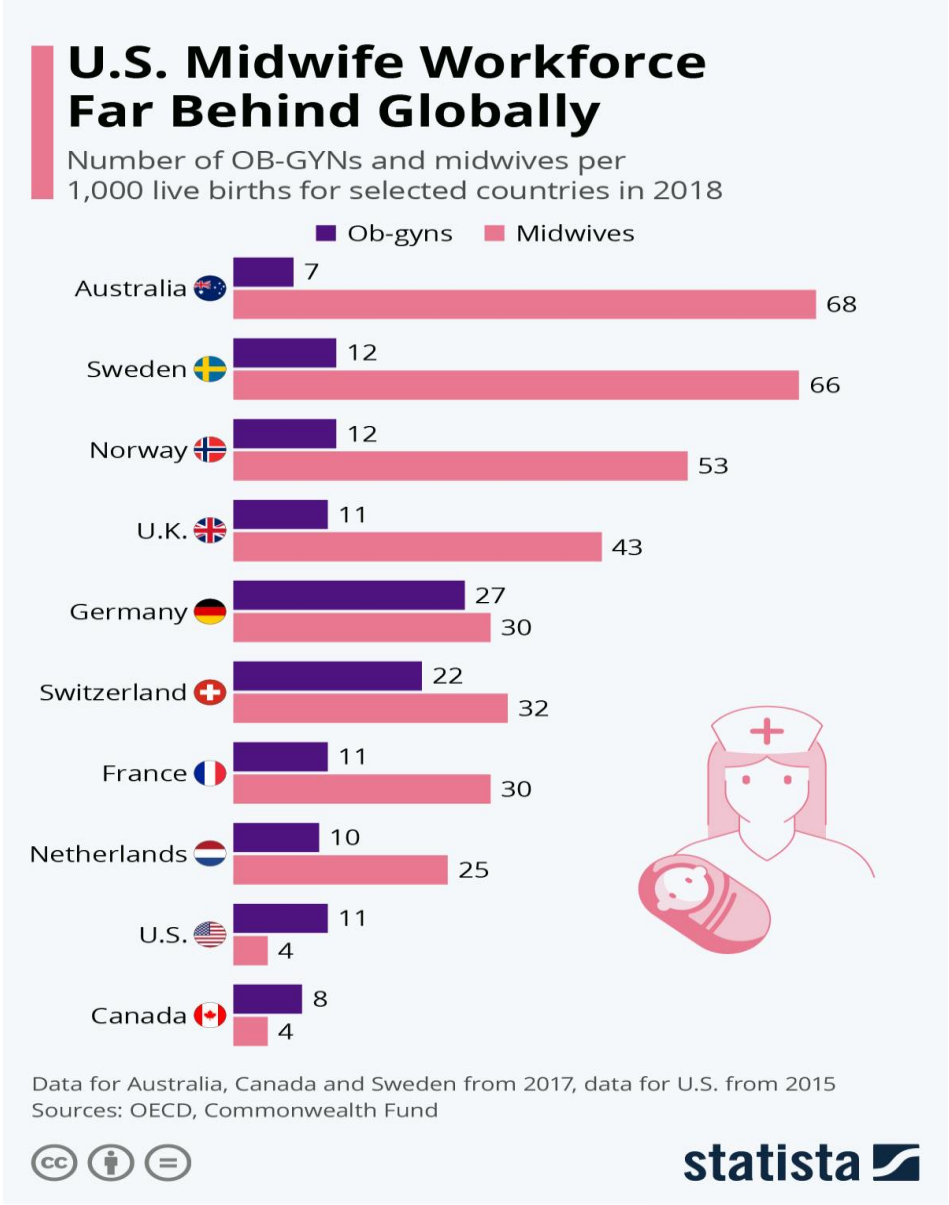
- US has worst maternal health outcomes among peer nations
- New Jersey is among the worst performing states
- Significant racial disparities across maternal mortality and morbidity
- Midwifery is a recognized pillar of high functioning reproductive and women's health care systems
- New Jersey licensing and regulation have limited the potential of the midwifery workforce over time
- Modernization can help expand the midwifery workforce and enable more families to experience quality midwifery care
- It is possible to reform and modernize New Jersey's legal and regulatory structures
- The time is now

Public Health 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
- Reduced hospital stays
- Reduce costs
- Increase patient centered care delivery
- Increase patient satisfaction and outcomes
- Improve access to family planning
- Increase rates of breastfeeding and its related benefits

Homer CS, Friberg IK, Dias MA, et al. The projected effect of scaling up midwifery. *Lancet*. 2014;384(9948):1146-1157.
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.
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. Accessed 04 June 2023.

U.S. midwifery workforce in context



Goals of Health Professional Licensing and Regulation

Goals:

✓ public safety

✓Standards of care

✓consumer protection, quality control (complaints, discipline and enforcement)

✓Clarity in title and scopes of practice (education, training, credentials)

✓Registration, continuing education and relicensing

***Not* goals:**

X Narrowing scopes of practice to give competitive advantage to other professions (*NC Dental)*

X Unjustified workforce suppression via barriers to entry

X Exclusion or discrimination against specific populations of potential professionals

Basic Classification of Midwifery License Types in the U.S. (all offered in NJ)

(Source: ACNM, midwife.org)

CNM: Certified Nurse-Midwives (CNMs) are registered nurses who have graduated from a midwifery education program accredited by the Accreditation Commission for Midwifery Education (ACME) and have passed a national certification examination administered by the American Midwifery Certification Board, Inc. (AMCB), formerly the American College of Nurse-Midwives Certification Council, Inc. (ACC).

CM: Certified Midwives (CMs) are graduates of a midwifery education program accredited by ACME and have successfully completed the AMBC certification examination and adhere to the same professional standards as certified nurse-midwives. Obstetricians-gynecologists (OB-GYNs) pass a national certification exam administered by the American Board of Obstetrics and Gynecology or Osteopathic Board and enter ongoing Maintenance of Certification.

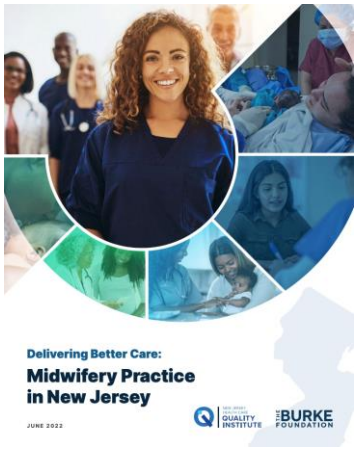
CPM: Certified Professional Midwives (CPMs) enter the profession through various routes including apprenticeship programs or educational programs accredited by the Midwifery Education Accreditation Council (MEAC). The MEAC educational programs may grant a certificate, an associates, bachelors, masters or doctoral degree. Most graduates obtain a certificate or associates degree. CPMs are authorized to practice in 28 states.

NATIONAL MIDWIFERY CREDENTIALS IN THE UNITED STATES OF AMERICA	CERTIFIED NURSE-MIDWIFE (CNM)	CERTIFIED MIDWIFE (CM)	CERTIFIED PROFESSIONAL MIDWIFE (CPM)
LICENSURE			
Legal Status	Licensed in 50 states plus the District of Columbia and US territories as midwives, nurse-midwives, advanced practice registered nurses, or nurse practitioners	Licensed in Delaware, Maine, New Jersey, New York, and Rhode Island	Licensed or otherwise regulated in 31 states (4 states regulate by registration, certificate or voluntary licensure)
Licensure Agency	Boards of Midwifery, Medicine, Nursing, Nurse-Midwifery, or Departments of Health	Boards of Midwifery, Medicine, Complementary Health Care Providers or Departments of Health	Boards of Midwifery, Medicine, Nursing, Complementary Health Care Providers or Departments of Health or Departments of Professional Licensure

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)

Autonomy and Midwifery Practice: Key Definitions and Overlapping Terminology

"Autonomous" practice regulation recognizes midwives as independent practitioners of midwifery.

"Full practice authority" refers to the ability of providers to autonomously practice to the full extent of their education, clinical training and certification

- Eliminates the requirement for formal supervision by physicians
- Does not require a contract with a physician
- Preserves clinical practice guidelines to establish and maintain collaborative relationships (e.g. with physicians and hospitals)
- Requires notice to patients of the parameters of collaboration and referral.

Autonomous Practice

International Confederation of Midwives (ICM) holds elements of an autonomous profession must include:

- a unique body of knowledge
- a code of ethics
- self-governance
- processes for decision-making by its members
- recognition from society through regulation

"Self-governing, self regulating: taking responsibility for one's decisions and actions. The autonomous midwife provides care during the course of pregnancy, labour, birth and the postnatal period and makes decisions in partnership with each woman in her care. The midwife is responsible and accountable for all decisions she makes and the care she provides without delegation from or supervision or direction by any other health care provider." (ICM definition)

Licensing and Regulation in New Jersey


BOARD OF MEDICAL EXAMINERS LAW AND PUBLIC SAFETY

NEW JERSEY ADMINISTRATIVE CODE
TITLE 13
LAW AND PUBLIC SAFETY
CHAPTER 35
SUBCHAPTER 2A
LIMITED LICENSES: MIDWIFERY

Chapter 35. Subchapter 2A Page 1 of 27 Last Revision Date: 3/1/2021

Authority to license and regulate derived from statute and regulation

- NJ Department of Law and Public Safety, Division of Consumer Affairs mission:
- "to protect the public from fraud, deceit, misrepresentation, and professional misconduct in the sale of goods and services in New Jersey through education, advocacy, regulation and enforcement."

Statute: N.J.S.A. 45:10-1 defines the practice of midwifery:

"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"

Regulations: NJAC 13:35-2A regulate the practice of midwifery

Regulatory purpose: "to protect the health and safety of the public through public licensure of midwives."

Current regulations

- Autonomous practice prohibited
- Agreement with consulting physician required

- Midwifery Liaison Committee (MLC) overseen by NJ Board of Medical Examiners (BME)
- Rulemaking process overseen by BME
- Current MLC composition:
  - “eight members who shall serve as consultants to the Board [BME] and who shall be appointed by the Board”
  - Three-year terms with opportunity for reappointment

Strengths and weaknesses of the current system

Strengths:

- Verification of education, experience and credentials
- Codification of nationally-recognized standards for practice
- Disciplinary framework

Weaknesses:

- Preventable harm and disparities
- Formal collaboration with physicians:
  - Increases malpractice costs
  - Decreases provider supply
  - Does not improve quality of care or outcomes

Frameworks for Assessment

Public health research focus on impact of:

- Autonomous practice environments
- Reimbursement coverage
- Workforce
- Health outcomes

Federal Trade Commission focus on:

- Competition
- Consumer protection
- Consumer benefit

Needed reforms include:

1. End New Jersey's prohibition of autonomous midwifery practice
2. Establish an Independent midwifery board
3. Prescriptive authority for Certified Midwives
4. Require reimbursement parity for equivalent services provided by midwives
5. Make midwife-assisted home birth eligible for Medicaid reimbursement
6. Make permanent the ability of CPMs to have privileges in birthing centers
7. Make permanent the ability for CMs to attend births in hospitals
8. Modify vital records to improve accuracy for midwifery-related data
9. Fund scholarships, clinical training placement sites and a CPM program

Autonomous midwifery practice

recognizing midwives as independent practitioners of midwifery

- Eliminate formal physician supervision requirement
- Licensure qualifications
  - Outlined in statute
  - Detailed in regulation
- CNMs and CMs: Prescriptive authorization
- CPMs: Dispense and administer (no prescriptive authority)
- Clinical practice guidelines establish and maintain collaborative relationships
  - CNM/ CM clinical practice guidelines set by American College of Nurse Midwives (ACNM)
  - CPM clinical practice guidelines set by North American Registry of Midwives (NARM)

Disciplinary and Enforcement Structure

- Violations of professional standards
- Board administered
- Department of Law and Public Safety/ Division of Consumer Affairs
- Uniform Enforcement Act

Home Birth

- Increased demand by 19% in 2020 (Pew Research Center)
- Benefits of transition plans:
  - Informed, regular communication in prenatal period
  - Advance planning
    - Transportation
    - Staffing
    - Notice procedures
    - Record sharing
    - Documentation
  - Evaluation mechanism
- Legislation can require transition planning (e.g. Washington State)
  - Departments of Law and Public Safety and Health

Vital Records

- Essential public health data
- Birth attendant accuracy (CNM, CM, CPM) integral to birth certificate integrity
- Intended place of birth indication needed to account for transitions
- Remove statutory bar to midwives signing certificates of fetal death

Considerations relevant to New Jersey's Midwifery Landscape

- Training and workforce development required to gain benefits of regulatory and licensure modernization:
  - Clinical training placements
  - Preceptor
  - Option to include integrated care training beyond accreditation requirements

See: United States Government Accountability Office. (2023, April). Information on births, workforce, and Midwifery Education.

- "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."

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

Considerations relevant to New Jersey's Midwifery Landscape

Admitting privileges

- Make permanent the ability of CPMs to have privileges in birthing centers
- Make permanent the ability for CMs to attend births in hospitals

Current Sites of Midwifery-Assisted Delivery Care in NJ
(by license type)

	Hospital	Birth Center	Home
CPM		✓ (*via waiver*)	✓
CM	✓	✓	✓
CNM	✓	✓	✓

Financial Considerations for New Jersey Midwives

- Reimbursement parity required for equivalent services provided by midwives
- Licensing fees may increase
  - Options for state support to defray
- Malpractice insurance requirement
- Other

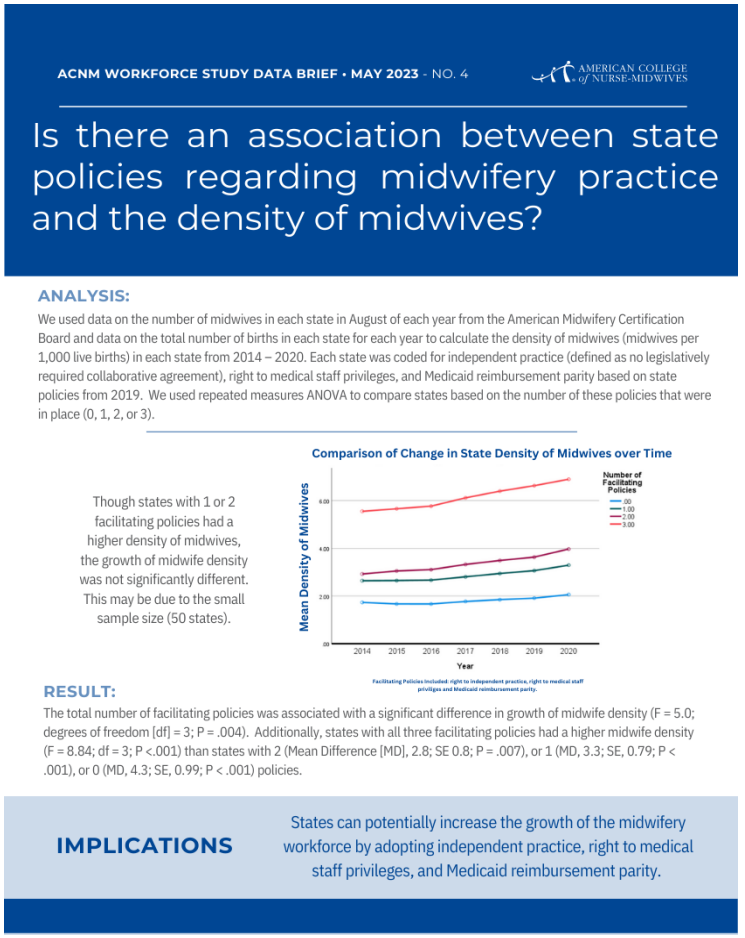
Midwifery license fees by state:

	New Jersey[63]	Washington[64]	Oregon[65]	New York[66]	California[67]	Texas
License or Initial Fees	**License Application** $125	**Initial Application** $541	**Initial Application** $800 or $450*	**Initial fee** $322	**Initial fee** $450	**Initial fee** $195[68]
Additional Fees	**Prescriptive Authority** $50 **Background Check** $19.37	**State Examination** $155	N/A	N/A	N/A	N/A
Renewal Frequency & Fees	**Biennial** $135 (even year) or $270 (odd year)	**Annual** $541	**Annual** $800	**Triennial** $322	**Biennial** $300	**Biennial** $390[69]

* As of 2020, Oregon offers $350 discount for certain direct entry midwifery license applicants

Expected benefits of Modernized Midwifery Licensing and Regulation

- Increased access to midwifery care
- Heightened focus on patient needs
- Increased midwifery workforce
- Professional autonomy
- Reduced costs
- Opportunity for inclusive process
- Improved maternal health equity and outcomes



ACNM WORKFORCE STUDY DATA BRIEF • MAY 2023 - NO. 4

AMERICAN COLLEGE of NURSE-MIDWIVES

Is there an association between state policies regarding midwifery practice and the density of midwives?

ANALYSIS:

We used data on the number of midwives in each state in August of each year from the American Midwifery Certification Board and data on the total number of births in each state for each year to calculate the density of midwives (midwives per 1,000 live births) in each state from 2014 – 2020. Each state was coded for independent practice (defined as no legislatively required collaborative agreement), right to medical staff privileges, and Medicaid reimbursement parity based on state policies from 2019. We used repeated measures ANOVA to compare states based on the number of these policies that were in place (0, 1, 2, or 3).

Though states with 1 or 2 facilitating policies had a higher density of midwives, the growth of midwife density was not significantly different. This may be due to the small sample size (50 states).

Comparison of Change in State Density of Midwives over Time

Facilitating Policies Included: right to independent practice, right to medical staff privileges and Medicaid reimbursement parity.

RESULT:

The total number of facilitating policies was associated with a significant difference in growth of midwife density (F = 5.0; degrees of freedom [df] = 3; P = .004). Additionally, states with all three facilitating policies had a higher midwife density (F = 8.84; df = 3; P <.001) than states with 2 (Mean Difference [MD], 2.8; SE 0.8; P = .007), or 1 (MD, 3.3; SE, 0.79; P < .001), or 0 (MD, 4.3; SE, 0.99; P < .001) policies.

IMPLICATIONS

States can potentially increase the growth of the midwifery workforce by adopting independent practice, right to medical staff privileges, and Medicaid reimbursement parity.

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

Review: Reforms include:

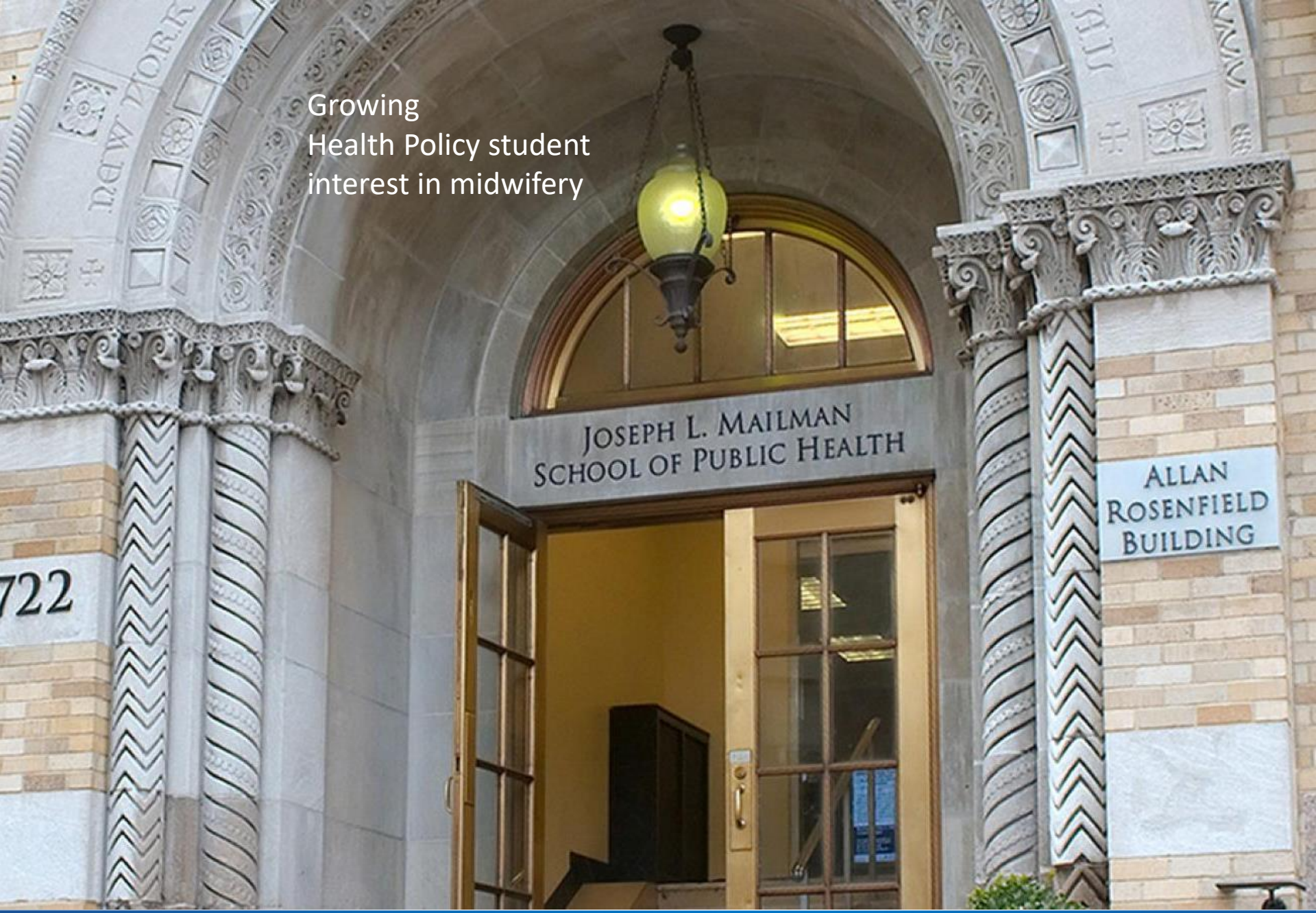
1. End New Jersey's prohibition of autonomous midwifery practice
2. Establish an Independent midwifery board
3. Prescriptive authority for Certified Midwives
4. Require reimbursement parity for equivalent services provided by midwives
5. Make midwife-assisted home birth eligible for Medicaid reimbursement
6. Make permanent the ability of CPMs to have privileges in birthing centers
7. Make permanent the ability for CMs to attend births in hospitals
8. Modify vital records to improve accuracy for midwifery-related data
9. Fund scholarships, clinical training placement sites and a CPM program
10. Malpractice insurance

Evaluate law to inform public health policy:

- Grow the evidence base
- Document baseline features
- Track changes over time
- Identify impact and missed targets
- Identify modifications needed over time

Conclusion

- New Jersey would be a healthier, more equitable place to live if the structure governing midwifery were modernized
- Such changes are part of a larger landscape
- Rightsizing midwifery licensing, regulation and reimbursement are elements of:
  - Undoing structural racism in maternal health care
  - Improving public health
  - Meeting licensing-based public safety obligations
  - Securing consumer protection


Growing
Health Policy student
interest in midwifery
JOSEPH L. MAILMAN
SCHOOL OF PUBLIC HEALTH
ALLAN
ROSENFIELD
BUILDING
722

Thank you

Comments and Questions

Additional citations in Report

Keep in touch

Magda Schaler-Haynes

mes67@cumc.columbia.edu