Midwifery in the United States and the Consensus Model for APRN Regulation

The American College of Nurse-Midwives, the Accreditation Commission for Midwifery Education, and the American Midwifery Certification Board acknowledge the challenging and thoughtful work by the Advanced Practice Registered Nurse (APRN) Consensus Work Group, the APRN Joint Dialogue Group, the National Council of State Boards of Nursing (NCSBN) APRN Advisory Committee, and all those involved in the creation and ongoing dissemination of the Consensus Model for APRN Regulation.

Today, midwifery as practiced by certified nurse-midwives (CNMs) and certified midwives (CMs) encompasses primary care for women across the lifespan from adolescence through the postmenopausal period, with a special emphasis on pregnancy, childbirth, and reproductive health. The scope of practice for CNMs and CMs also includes treatment of male partners for sexually transmitted infections, and care of the normal newborn during the first 28 days of life.

While many of the provisions of the Consensus Model have already been accomplished in the midwifery profession, and others are easily implemented, some are more challenging. The purpose of this document is to address those provisions requiring special consideration in their application to midwifery practice and to provide a clear road map for their implementation.

Evolution of the Midwifery Profession and the American College of Nurse-Midwives (ACNM)

Midwifery has existed as a distinct profession throughout the history of human civilization and the history of the United States. Historically and to date, in most countries around the world where midwives are the predominant providers of maternity care, midwifery education is not based upon nursing other than encompassing a shared goal of health and wellness.

In the United States, traditional midwives were marginalized during the formalization of medicine at the turn of the 20th century, and generally prohibited from mainstream education and practice. By 1920, as the demand for maternity care services surpassed provider supply, professional nurse-midwifery was introduced by expanding the role of some public health nurses to include midwifery practice. The American College of Nurse-Midwives (ACNM), the professional association that now represents certified nurse-midwives and certified midwives in the United States, was incorporated in 1955. By 1970, ACNM had developed functions, qualifications, and midwifery standards of practice; established criteria for the accreditation of educational programs, now overseen by the Accreditation Commission for Midwifery Education (ACME); and implemented a national certification exam, now overseen by the American Midwifery Certification Board (AMCB). In 1978, core competencies for

basic midwifery practice were published as a basis for midwifery education. Through the next several decades, the profession of nurse-midwifery grew as more schools were established.

In an attempt to address provider shortages in the early 1990s and to increase women's access to health care, ACNM strategically began to reconsider the requirement of nursing as a prerequisite to the profession of midwifery. Having identified the educational components that must be attained prior to entry into midwifery education, ACNM collaborated with ACME and ACMB to develop accreditation criteria and a certification mechanism for individuals not educated in nursing programs. The certified midwife (CM) credential was formally established in 1996. **CMs have the same core education requirements, attain the same theoretical and clinical competencies, and take the same certification exam as certified nurse-midwives (CNMs).**

ACNM has also developed a midwifery credential comparison chart in an effort to aid health professionals, state-licensing boards, legislators, and consumers to quickly compare midwifery credentials among CNMs, CMs, and other types of midwives (see Appendix A).

Implementation of the APRN Consensus Model for Midwifery Practice

ACNM, ACME, and AMCB are united in strong support of many provisions of the Consensus Model. National certification — by way of a certification exam — was instituted as a requirement for CNMs in 1971. This same certification exam has been used for CMs to obtain their credential since the inception of the CM credential in 1998.

We provide the following recommendations regarding implementation of the model for CNMs, with potential implications for CMs in the future.

1. **PRACTICE AUTONOMY.** The Consensus Model's "Foundational Requirements for Licensure" advocate that APRNs be licensed "as independent practitioners with no regulatory requirements for collaboration, direction or supervision" (p. 13). These requirements are essential to the effective implementation of the Consensus Model for midwifery practice and APRNs. It has been clearly demonstrated that supervisory language and collaborative agreement requirements represent needless barriers to APRN practice and access to health care services, while providing no benefits in quality of care. The Consensus Model clearly and repeatedly supports that APRNs are autonomous practitioners.

   We recognize that this has been an important focus for the APRN Consensus workgroup, the APRN Joint Dialogue Group, and the NCSBN APRN Advisory Committee. However, in some states, legislation and rule changes have been proposed which have not eliminated supervisory language and collaborative agreement requirements. It will be essential for all of us to be alert to this language in the future to foster the independent practice proposed in the Consensus Model.

   Our medical colleagues in obstetrics and gynecology endorse the principles of APRN autonomy. ACNM and the American College of Obstetricians and Gynecologists (ACOG) have been working closely together to enhance practice models to address mounting maternity workforce shortages. As early as 2002, ACOG recognized the equivalency of the CM and CNM credentials. The 2011 ACOG/ACNM "Joint Statement of Practice Relations Between Obstetricians and Gynecologists and Certified Nurse-Midwives/Certified Midwives" (*http://www.midwife.org/Ob-Gyns-and-Midwives-Seek-to-Improve-Health-Care-for-Women-and-Their-Newborns*) prominently asserts that "Ob-gyns

and CNMs/CMs are experts in their respective fields of practice and are educated, trained, and licensed, independent providers who may collaborate with each other based on the needs of their patients. Quality of care is enhanced by collegial relationships characterized by mutual respect and trust, as well as professional responsibility and accountability."

> **Recommendation 1:** ACNM, ACME, and AMCB urge state legislatures and regulatory boards to eliminate regulatory requirements for collaboration, direction, or supervision of APRNs in all 50 states, federal districts, and territories.

2. **LICENSING BOARDS FOR CNMs AND CMs.** The Consensus Model intends that advanced practice nursing professions be self-regulating and therefore not be regulated by Boards of Medicine. It also recognizes that CNMs may be regulated by Boards of Midwifery or Boards of Nurse-Midwifery. (Pg. 13, Reference 6).

> **Recommendation 2.1:** ACNM, ACME, and AMCB urge boards of nursing to support Boards of Midwifery or Boards of Nurse-Midwifery.

> **Recommendation 2.2:** In jurisdictions where it is not feasible to establish separate boards of midwifery, given that CMs have the same core education requirements, attain the same theoretical and clinical competencies, and take the same certification exam as CNMs, we urge state boards of nursing to expand their purview to include the licensing and regulation of certified midwives.

3. **POPULATION FOCI.** The Consensus Model recommends that APRNs be educated in *at least one* of six population foci (p. 6). The "women's health/gender related" population focus area was specifically created by the Joint Dialogue Group in formulating the Consensus Model to encompass the full scope of practice for both CNMs and Women's Health Nurse Practitioners. An issue for midwifery is that because none of the enumerated population foci clearly reflects the *full* scope of midwifery practice, it is possible for the breadth of midwifery scope to be misunderstood and inadvertently truncated. It has been confirmed by the framers of the Consensus Model and the NCSBN since its adoption and ongoing implementation that midwifery care includes primary care of women across the lifespan. It is imperative that midwives be recognized as primary care providers of women across the lifespan including selective care of women's male partners and their newborns.

> **Recommendation 3:** We affirm that midwives are to be licensed as educated in the "women's health/gender-related" population focus area with the understanding that this population focus area includes primary care for women from adolescence beyond menopause, care of male partners for sexually transmitted infections, and care of the normal newborn during the first 28 days of life.

4. **EDUCATIONAL REQUIREMENTS.** The Consensus Model specifies that educational requirements be consistent with those of each advanced practice specialty. ACME criteria for programmatic accreditation require that every midwifery education program provide an adequate number and type of specific clinical experiences for the student to achieve basic competency for entry into midwifery practice. These criteria are in alignment with the Consensus Model language that broad-based APRN education must, "ensure clinical and didactic coursework is comprehensive and sufficient to prepare the graduate to practice in the APRN role and population focus" (p. 11).

ACNM, ACME, and AMCB note that there is inconsistent language regarding clinical education requirements in Appendix A of the Consensus Model that describes the NCSBN criteria for evaluating certification programs (Criteria III, Elaboration 5). The NCSBN Model Rules criteria specify a minimum of 500 supervised hours for all APRN roles which is inconsistent with the Consensus Model language. This language is also inconsistent with the clinical education criteria from the accrediting body for certified registered nurse anesthetists (CRNAs).

> **Recommendation 4.1:** Correct Appendix A of the Consensus Model and the NCSBN Model Rules to be consistent with the Consensus Model language on p. 11.
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> **Recommendation 4.2:** Eliminate minimum requirements for clinical hours for licensure for CNMs since this is not a recommendation of the Consensus Model and is not consistent with competency-based education.

5. **ACADEMIC INSTITUTIONS.** The current Consensus Model has inconsistent and confusing language about graduate degree requirements. CNMs and CMs graduate from nursing and non-nursing programs. The Consensus Model clarifies that an APRN degree or certificate is received from an academic institution that is accredited by a nursing or nursing-related accrediting organization (p. 10). However, in several other sections of the document, the accrediting organization requirement is inaccurately shortened to "nursing accrediting organization."

   This language has led to a misinterpretation that all APRNs are required to have a graduate degree in nursing.

   Question 24 of the official ***APRN LACE FAQ's*** clarifies graduate degree requirements:

   > **Does the Consensus Model require a graduate degree in nursing?**
   >
   > No. The Consensus Model specifically states that "APRN education must be formal education with a graduate degree or post-graduate certificate (either post-master's or post-doctoral) that is awarded by an academic institution and accredited by a nursing or nursing-related accrediting organization recognized by the U.S. Department Of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA)" (p. 10). Although many types of nurse practitioners must have a graduate degree in nursing in order to take their national certification exams, this is not the case for nurse-midwives or nurse anesthetists.

   Some states continue to require a master's degree in nursing for CNM practice, which is inconsistent with language in the Consensus Model and prevents licensure of CNMs who have earned masters or doctoral degrees in midwifery, public health, health sciences, or other related disciplines. Programs which offer such degrees afford and assess precisely the same competencies and skills and qualify applicants to sit for the AMCB examination which confers the CNM and CM credentials. These restrictive requirements create significant and unnecessary barriers for the many CNMs graduating from non-nursing programs. The goal of ACNM, ACME, and AMCB is that all AMCB-certified midwives have the opportunity to be licensed and regulated in all 50 states, federal districts, and territories.

Recommendation 5.1: We request that language about graduate education in nursing and nursing-related fields be clarified and reinforced in all documents and Web sites concerning the Consensus Model document.

Recommendation 5.2: We urge the APRN Consensus Work Group, the APRN Joint Dialogue Group, the NCSBN APRN Advisory Committee, and all those involved in the creation and ongoing dissemination of the Consensus Model for APRN Regulation to actively support the acceptance of graduate degrees in other fields for the practice of midwifery.

In Conclusion

ACNM, ACME, and AMCB support the opportunities the Consensus Model presents for improved standardization of APRN licensure, accreditation, certification, and education based on the principle of APRN practice autonomy.

Licensing boards play a central role in Consensus Model implementation efforts by directly promulgating regulatory amendments, helping to craft legislation, and providing expertise on the nature of and need for each provision. We express our shared position that licensing boards must give greater primacy to ensuring that Consensus Model implementation efforts include provisions to strike supervisory and collaborative agreement barriers to practice.

There is documented evidence that providing greater practice autonomy for APRNs and midwifery expands access to and the quality of patient care. This autonomy is based on individual accountability together with collaboration, consultation, and referral with physicians and other health care providers according to the individual needs of our patients. By embracing this provision, licensing boards, state legislators, and regulators will be playing an important role in addressing a looming shortage of primary care and maternity care providers.

At the same time, we note the importance of closely heeding those Consensus Model provisions that carefully communicate distinct requirements for the APRN professions. While these distinctions may appear nuanced, they were thoughtfully reflected in the Consensus Model because they represent fundamental components to each professional role. We present the recommendations provided above as ideal implementation approaches to the Consensus Model for midwifery practice.

ACNM, ACME, and AMCB welcome the opportunity to serve as resources in the implementation of this model related to midwifery practice. We look forward to a future where the professions of nursing and midwifery work together to provide safe, effective, and high-quality care to women and their families without regulatory barriers to our full scopes of practice.

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APPENDIX A: Comparison of Certified Nurse-Midwives, Certified Midwives, and Certified Professional Midwives

*Clarifying the distinctions among professional midwifery credentials in the U.S.**

	CERTIFIED NURSE-MIDWIFE (CNM®)	CERTIFIED MIDWIFE (CM®)	CERTIFIED PROFESSIONAL MIDWIFE (CPM)®
PROFESSIONAL ASSOCIATION			
	American College of Nurse-Midwives (ACNM)		Midwives Alliance of North America (MANA) and National Association of Certified Professional Midwives (NACPM)
CERTIFICATION			
Certifying Organization	American Midwifery Certification Board (AMCB)**		North American Registry of Midwives (NARM)**
Certification Requirements (minimum degree and other requirements prior to taking national certifying exam)	Graduate degree required		No degree required
	1. Graduation from a nurse-midwifery education program accredited by ACNM Accreditation Commission for Midwifery Education (ACME); AND 2. Verification by program director of completion of education program; AND 3. Active registered nurse (RN) license	1. Graduation from a midwifery education program accredited by ACNM Accreditation Commission for Midwifery Education, (ACME); AND 2. Verification by program director of completion of education program	1. Completion of NARM's Portfolio Evaluation Process (PEP) pathway; OR 2. Graduate of a midwifery education program accredited by Midwifery Education Accreditation Council (MEAC); OR 3. AMCB-certified CNM or CM; OR 4. Completion of state licensure program.
Recertification Requirement	Every five years		Every three years
EDUCATION			
Minimum Education Requirements for Admission to Midwifery Education Program	Bachelor's degree from accredited college/university 1. Some programs require RN license. If the applicant has a bachelor's degree, but not an RN license, some programs will require attainment of an RN license prior to entry into the midwifery program; others will allow the student to attain an RN license prior to graduate study; OR 2. If the applicant is an RN but does not have a bachelor's degree, some programs provide a bridge program to a bachelor's degree prior to the midwifery portion of the program; other programs require a bachelor's degree before entry into the midwifery program.	Bachelor's degree from accredited college/university and successful completion of specific science courses	There are two primary pathways for CPM education, with differing admission requirements: 1. Portfolio Evaluation Process (PEP) pathway: an apprenticeship program; no degree or diploma required. Student must find a midwife preceptor who is nationally certified or state licensed, has practiced for at least 3 years, and attended at least 50 out-of-hospital births; OR 2. Accredited formal education pathway: For this pathway, a high school diploma from an accredited state or private school is required for admission.
	Note: Currently, the majority of AMCB-certified midwives enter midwifery through nursing.		*Note: Currently, the majority of CPMs have completed the apprenticeship-only (PEP) pathway to the CPM credential.*

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Clarifying the distinctions among professional midwifery credentials in the U.S. (Continued)*

	CERTIFIED NURSE-MIDWIFE (CNM®)	CERTIFIED MIDWIFE (CM®)	CERTIFIED PROFESSIONAL MIDWIFE (CPM)®
EDUCATION (continued)			
Clinical Experience Requirement	Attainment of clinical skills must meet Core Competencies for Basic Midwifery Education (ACNM 2008). Clinical education must occur under the supervision of an AMCB-certified CNM/CM or Advanced Practice RN (APRN) who holds a graduate degree and has clinical expertise and didactic knowledge commensurate with the content taught. Clinical skills include management of primary care for women throughout the lifespan, including reproductive health care, pregnancy, and birth; care of the normal newborn; and management of sexually transmitted infections in male partners.		Attainment of clinical skills must meet the Core Competencies developed by the Midwives Alliance of North America. Clinical education must occur under the supervision of a midwife who must be nationally certified, legally recognized and who has practiced for at least three years and attended 50 out-of-hospital births. Clinical skills include management of prenatal, birth and postpartum care for women and newborns.
Degree Granted	Master's or doctoral degree; a master's degree is the minimum requirement for the AMCB certification exam	Master's degree; a master's degree is the minimum requirement for the AMCB certification exam	No degree is granted through the PEP pathway. MEAC-accredited programs vary and may grant a certificate or an associate's, bachelor's, master's, or doctoral degree. Most graduates attain a certificate or associate degree; there is no minimum degree requirement for the CPM certification exam.
ACCREDITING ORGANIZATION			
	The Accreditation Commission for Midwifery Education (ACME) is authorized by the US Department of Education to accredit midwifery education programs and institutions.		The PEP pathway is not eligible for accreditation. The Midwifery Education Accreditation Council (MEAC) is authorized by the US Department of Education to accredit midwifery education programs and institutions.
LICENSURE			
Legal Status	Licensed in all 50 states plus the District of Columbia and US territories	Licensed in New Jersey, New York, and Rhode Island. Authorized by permit to practice in Delaware. Authorized to practice in Missouri.	Regulated in 26 states (variously by licensure, certification, registration, voluntary licensure, or permit)
Licensure Agency	Boards of Nursing, Boards of Medicine, Boards of Midwifery/Nurse-Midwifery, Departments of Health	Board of Midwifery, Board of Medicine, Department of Health	Departments of Health, Boards of Medicine, Boards of Midwifery

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Clarifying the distinctions among professional midwifery credentials in the U.S. (Continued)*

	CERTIFIED NURSE-MIDWIFE (CNM®)	CERTIFIED MIDWIFE (CM®)	CERTIFIED PROFESSIONAL MIDWIFE (CPM)®
SCOPE OF PRACTICE			
Range of Care Provided	Independent management of women's health care throughout the lifespan, from adolescence through menopause. Comprehensive scope of practice including primary care and gynecologic care, family planning, annual exams (including breast and PAP screening), pregnancy, birth in all settings, and postpartum care. Care of the normal newborn. Management of sexually transmitted infections in male partners.		Independent management of care for women and newborns during pregnancy, birth, and postpartum. Birth in homes and birth centers. Care of the normal newborn.
Prescriptive Authority	All US jurisdictions	New York	None. However, may obtain and administer certain medications in some states.
Practice Settings	All settings — hospitals, birth centers, homes, and offices. The majority of CNMs and CMs attend births in hospitals.		Homes, birth centers, and offices. The majority of CPMs attend out-of-hospital births.
THIRD-PARTY REIMBURSEMENT			
	Most private insurances; Medicaid coverage mandated in all states; Medicare; Champus	New York, New Jersey, Rhode Island—most private insurance; Medicaid	Private insurance in some states; Medicaid in 10 states for home birth, additional states if birth occurs in birth center.

** This document does not address individuals who are not certified and who may practice midwifery with or without legal recognition.*

*** AMCB and NARM are accredited by the National Commission for Certifying Agencies, which "was created in 1987 ... to help ensure the health, welfare, and safety of the public through the accreditation of a variety of certification programs/organizations...Certification organizations ... are evaluated based on the process and products, not the content, and are therefore applicable to all professions and industries.." (http://www.credentialingexcellence.org/ProgramsandEvents/NCCAAccreditation/tabid/82/Default.aspx)*

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