AMERICAN COLLEGE
of NURSE-MIDWIVES

MIDWIFERY POLICY TOOLKIT

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INTRODUCTION

The American College of Nurse-Midwives conducted a two-year study of the midwifery workforce. The workforce study generated information on the supply of advanced practice midwives, that is Certified Nurse-Midwives (CNMs) and Certified Midwives (CMs) (hereinafter referred to as "midwives"), in the United States. These data are critical to better understand midwifery workforce needs and to inform the policy work needed to increase access to advanced practice midwives (APMs) and improve maternal mortality and morbidity rates nationwide. Data from the Workforce Study are available on ACNM's website, https://www.midwife.org/midwifery-workforce. In addition to the descriptive data, ACNM has created comprehensive resources for midwives to use for advocacy. This Advocacy Toolkit for Midwives provides a road map for developing strategies to increase access to midwives and midwifery-led care models and to grow the midwifery workforce. The national and state data in this toolkit inform these initiatives.

PROBLEM:

Midwifery is associated with a host of good outcomes for childbearing individuals, yet most people in the United States do not have access to midwives.

According to the World Health Organization (WHO), midwives could be providing 90% of sexual and reproductive care in the United States but the predominant structure of the US healthcare system is not set up to support midwives or midwifery-led care models. Midwives, incorporated fully into US maternity care systems, could reduce perinatal health disparities, and help address provider workforce shortages. The barriers that midwives face to scale up in number of midwives and provision of services translate into a lack of access to midwives for consumers. For instance, many midwives across the country are reimbursed less for providing care than physicians by both private and public insurers. This creates problems for access: practices don't want to hire midwives if the midwives generate less income than physicians. Another barrier is the restriction of autonomous practice by state laws and regulations that treat the work of midwives as an extension of physician work. Restrictions of midwifery autonomy and scope of practice make it difficult for midwives to practice the midwifery model of care. Midwives often are relegated to the role of physician extenders which deprives consumers of the benefits of the midwifery model and the potential benefits of midwifery care. In addition – in 48 states, there is no law protecting midwives' right to admit their own patients to hospitals, which is the primary location of

birth for most people in the United States. Even more detrimental to access to midwifery care, hospitals can exclude midwives all together and choose not to offer midwifery. Midwifery in hospitals should be available to consumers in the same way that pediatrics, family practice, or other health care specialties are.

RATIONALE FOR WORKFORCE STUDY:

Assessing the viability of the current midwifery workforce is integral to planning expansion of midwifery. Existing workforce data for CNMs and CMs is not easily accessible, and the Workforce Study presented ACNM with an opportunity to do the research necessary to gather this information. ACNM has compiled workforce information about midwifery that is valuable to many key partners, including midwives, health insurers, legislators, consumer advocates, other maternal health agencies, hospital administrators, and more. ACNM used publicly available data along with data from the national certifying body for CNMs and CMs, the American Midwifery Certification Board, to create a more accurate picture of the location and density of midwives than has been available in the past. We also conducted a mixed-methods evaluation with APMs who had left the workforce to understand reasons for workforce attrition.

RESOURCES FOR SOLUTIONS:

This toolkit is for midwives and midwifery advocates to find ways to address state-level barriers so that midwives can practice to the full extent of their education, clinical training, and certification. There are three companion pieces. The first is the National Midwifery Chartbook, which is a slide deck about the current midwifery workforce from a national perspective. The second is a State Chartbook - a slide deck of state-specific facts and entification of areas of policy that could be changed to improve to ability to scale up midwives and increase access to midwifery care. The third piece is the group of State Fact Sheets, a two-pager for distribution. The State Chartbook and State Fact Sheets are an ACNM Member Benefit.

POLICY PRIORITIES:

Independent practice - State licensing is the process by which a state confirms that a healthcare worker is competent to practice and designates the health care worker as legally able to practice within the state. Requirements for licensing are generally set by state statute or regulation and the licensing process is overseen by a regulatory authority in the state. In "independent" states, midwifery licensure is based on evidence of education and certification. In "restricted" states, midwives are required to provide evidence of a written contract with a physician to be licensed to provide midwifery care, in addition to evidence of education and certification. There is no demonstrated benefit to restricted practice, and removal of the requirement for contractual relationships with physicians is a policy goal.

Parity in reimbursement - parity means midwives receive the same rate of reimbursement as a physician when they are providing the same service. Changing state regulation so that midwives receive 100% of physician fees from Medicaid is a policy goal.

Independent admitting privileges, preferably Medical Staff privileges - The Medical Staff is a body of healthcare providers who are authorized by the hospital and state law to provide health care within a specific hospital. Midwives who are part of the Medical Staff can independently admit and discharge patients, and admitting privileges for midwives is a policy goal.

Midwifery organizational representatives meeting with Senator Amy Klobuchar's (D-MN)
Staff to discuss expanding access to midwives, birth centers, and midwifery-led care models.

PURPOSE & ROLE OF MIDWIFERY IN THE MATERNAL HEALTH SYSTEM

Board-certified midwives are educated in graduate-level midwifery programs accredited by the Accreditation Commission for Midwifery Education (ACME) and must pass a national certification exam administered by the American Midwifery Certification Board (AMCB). Board-certified midwives practice in accordance with the American College of Nurse-Midwives (ACNM) Standards for the Practice of Midwifery. Basic competencies for board-certified midwifery practice meet or exceed the global competencies and standards of practice for midwifery as defined by the International Confederation of Midwives. Midwifery as practiced by Certified Nurse-Midwives (CNMs) and Certified Midwives (CMs) encompasses the independent provision of care during pregnancy, childbirth, and the postpartum period; primary care; sexual and reproductive health; gynecologic health; and family planning services, including preconception care.

The United States' state maternal health systems often restrict midwives' practice or exclude midwives from the health system. In some states, midwifery licensing requirements prevent midwives from opening practices in communities without obstetricians. Families seeking midwifery care face barriers due to the lack of inclusion of midwifery services in health insurance coverage. State regulations that require a physician co-signature for hospital midwifery care disincentivize hospitals and physicians from hiring midwives because they cannot work autonomously. This is one factor that has created a shortage of midwives and limited the percentage of births (10.9%) that were attended by board-certified midwives in 2022. This is one of the lowest proportions of midwife-attended births of any industrialized nation.

Other factors contributing to an underusage of midwifery care are based in the history of midwifery and nurse-midwives in the United States. There was a systematic movement by physicians to eliminate the profession of midwifery during the early 20th century that was rooted in racism and effectively caused thousands of Black, Indigenous, and immigrant midwives to stop practicing by the mid-20th century. While midwifery re-emerged when public health midwives trained as nurses and eventually became CNMs, midwifery has not

yet returned to a valued place in the health care system as it was prior to its elimination. This legacy of systematically excluding people of color, lack of respect for the profession of midwifery, and underpayment of midwives continues to affect workforce size.

Midwifery care can be cost-effective and sustainable when implemented correctly and fully integrated into the healthcare service delivery design. Evidence suggests this can be achieved without compromising the quality of care or increasing costs. This is because maternal care system is more efficient when midwives can practice to their full scope. Investment in midwifery regulation reform will maximize midwifery contributions to maternal health and safety and ensure quality care for patients.

Changes in state policy will have a limited effect on increasing the capacity of the midwifery workforce if there are not also changes in midwives' professional work environments. Midwives work in fragmented models of care where their ability to provide efficient and high-quality services may be limited by requirements for physician co-signature or oversight of practice. When midwives are prevented from serving in leadership positions, midwives may be restricted from practicing according to the midwifery model. This creates an environment of conflict, contributes to midwifery burnout and exit from practice, and prevents midwives from achieving the high-quality outcomes associated with midwifery care. Effective measures to identify and remove systemic barriers to midwifery care are needed to achieve these objectives.

Who should use this toolkit?

This toolkit was created for anyone who is working to expand the size or capacity of the midwifery workforce. This could include midwives, hospital administrators, legislators, members of midwifery organizations, departments of health, insurance companies, and others.

The information contained in this toolkit will help you identify and address the policy barriers to expanding midwifery in your state. Most importantly, this toolkit will help translate information about the barriers midwives face into the language used by policymakers and administrators.

How to use this toolkit

This toolkit will provide an overview of the following topics: midwifery and the maternal health system, engaging strategic partners, policy strategy, and advocacy strategies. Each section will provide a different set of vital information for successfully implementing new policy. This toolkit will provide policy makers with an understanding of the challenges facing the midwifery workforce. This toolkit will provide midwives a better understanding of the policy process.

The data in this toolkit is specific to midwives certified by the American Midwifery Certification Board. This is because, in most states, policies that govern board-certified midwives are in different statutes and regulations than the policies that govern other types of midwives. Therefore, it was not possible to analyze midwives as a single workforce. However, global data demonstrates that midwives are best able to provide care when fully incorporated into the health system and allowed to practice to their full scope. Given this, it is very likely that a similar study of policy restrictions on other midwives would come to the same conclusions as this work.

Georgetown nurse-midwifery student meeting with Senator John Tester (D-MT) to raise awareness and support for federal funding for midwifery education programs.

MIDWIFERY &
THE HEALTH SYSTEM

Certified Nurse-Midwives and Certified Midwives are master's or doctorally prepared health workers who provide care during pregnancy, childbirth, the postpartum period, sexual and reproductive healthcare, gynecologic healthcare, and family planning services. Midwives also provide primary care for individuals from adolescence throughout the lifespan and care for healthy newborns during the first 28 days of life. The American Midwifery Certification Board reports the United States had 14,198 Certified Nurse-Midwives and Certified Midwives as of December 2023, which is fewer than than 4 midwives for every 1,000 births. The World Health Organization estimates that health systems need a minimum of 6 midwives per 1,000 births to provide adequate care. This means the United States has a shortage of midwives. One reason for the midwife shortage is the failure to incorporate the work of midwives into the health system.

The health system refers to the organizations, people, and actions that maintain the health of people. The health system includes the facilities where people receive care, the health workers who provide the care, the financing organizations that distribute funds, the companies that build and distribute the supplies, and the information technology that allows collection and communication of the data. A well-functioning health system means a trained and motivated workforce has access to well-maintained infrastructure, a reliable supply of medicines and technologies, is backed by adequate funding, and has strong evidence-based policies to support the work. Increasing the size of the midwifery workforce will require incorporating the work of midwives into each of these areas.

The work of incorporating midwives into the health system is policy change work, sometimes referred to as health system reform. Policy improvements need to be made to allow midwives to work to their full potential. This includes ensuring midwives can operate within the full scope of their education, removing requirements that midwives be co-located with physicians, permitting midwives to use all available telehealth technologies, and ensuring midwives are included in reimbursement systems.

Policy change is also needed to track the improvements to the health system due to incorporating midwives. Our health information systems can capture quality improvement measures that allow data-driven decisions for change. Though these systems track patient outcomes and costs of care, the work of midwives is often attributed to physician colleagues. For example, care conducted by midwives will often be recorded in the

physician's name, especially in states where midwives have requirements for supervision or written collaborative agreements.

Finally, policy change is needed to ensure the sustainability of the health system and the health workforce. The shortage of maternity workers is not new but appears to be getting worse. The rate of burnout is increasing. A system that keeps workers healthy is needed to keep the system running. Up to 30% of midwives are not in clinical practice five years after initial certification. This rate of attrition will make it difficult to increase the size of the workforce. Policy changes at the governmental and hospital levels are an essential component of preventing early exit from midwifery.

The rest of this section will explore these issues from a variety of health system lenses. Each lens provides a different perspective on the challenge of increasing the size of the midwifery workforce.

Health Service Delivery

Health service delivery is the infrastructure that allows access to care. It includes all the places people receive services and supplies, including preventive care, diagnosis and treatment, and management of chronic conditions. Midwives deliver services in a variety of locations including hospitals, freestanding birth centers, primary care offices, health departments, rural health and federally qualified health centers, community clinics, and homes. The key characteristics of good service delivery are comprehensiveness, accessibility, coverage, continuity, quality, person-centeredness, coordination, accountability, and efficiency.

The major challenge to midwifery service delivery is accessibility. Accessibility to health services has multiple dimensions that include the physical, economic, and socio-psychological barriers to the use of health services. Challenges to access to midwifery services can be described using the five dimensions of access first proposed by Penchansky and Thomas in 1981: affordability, availability, accessibility, accommodation, and acceptability.

Dimensions of Midwifery Access

Affordability of services includes both the cost of the service and the ability of individuals to pay. There are multiple ways that affordability of services reduces access to midwifery care. In states that do not ensure midwives are included in health insurance plans, midwifery care is only accessible to those who can pay cash for services. In states where Medicaid reimbursement does not equitably reimburse midwives, midwives cannot accept Medicaid insurance. When health financing systems exclude midwifery care, access to midwifery care is limited. Making midwifery services affordable requires fully incorporating midwives into health financing systems.

Availability refers to the physical presence of services that meet minimum care standards. If midwifery care is available, it means the facility has midwives and the midwives have all the tools they need to do their work. A major way that midwife availability is limited is by hospitals that do not allow midwives to join the medical staff and admit patients. In states where hospitals are required to restrict admitting privileges to physicians, policy change can increase the availability of midwifery services.

Accessibility is a measure of the geographic availability of services. Accessibility of midwives is limited when midwives are restricted from providing services independently. States that require midwives to obtain a written practice agreement with a physician have less midwife availability because the supply of midwives is shifted from public demand for midwife services to physician demand for midwife employees. In the most restrictive states, midwives are required to be co-located with their physician colleagues which prevents midwives from providing care in areas without physicians.

Accommodation means that the services available meet the population's needs and preferences. This can refer to the types of services offered, the hours of operation, and methods of communication. State policy restricts the accommodation of midwifery services when midwives are prevented from providing care in birth centers or homes. State policies also restrict the accommodation of midwifery services when midwives are excluded from providing services via telehealth.

Acceptability of services means the clients are comfortable with the provider and the provider is comfortable with the client. Acceptability of midwifery services is reduced through implicit and systemic biases and discrimination. The midwifery workforce does not reflect the diversity of the people midwives serve. Improving the acceptability of midwifery services requires policy change to achieve equity in midwifery education.

Measuring Service Delivery

When estimating midwifery service delivery, all dimensions of access should be considered. Midwife service-specific readiness measures can be used. Statistical analysis can be of assistance because it provides consistent measurement over time to show progress. Statistical analysis can also allow a comparison of progress in different communities to identify priority areas for action. For example, comparing state midwife-specific measures of service delivery helps identify policies associated with growing the midwifery workforce. Examples of midwife-specific health service measures include:

- Number of midwives per 1,000 live births
- Proportion of maternity hospitals with midwives
- Proportion of midwife-attended births
- Proportion of midwives included in insurance panels

Improving Health Service Delivery

The goal of improving health service delivery is to achieve the Triple Aim. The Triple Aim includes three co-occurring system improvements: improve the patient experience, improve the health of populations, and reduce the costs of health care. Improving patient experience includes improving the quality and satisfaction of patient care. Improving the health of populations includes reducing rates of poor outcomes and removing disparities. Improving costs of health care includes reducing overall costs through preventive care and adopting cost-saving technology.

In the United States, progress on the Triple Aim relies on standardized measures of quality, safety, and cost that are used to track service delivery performance. These standardized measures are used to describe national and state goals through Healthy People and Title V. Standardized measures are also used in payment reform based on value-based care. Midwives may be familiar with the standardized measures because some are used in hospital accreditation or are the focus of state quality initiatives through perinatal quality collaboratives.

Focusing health system improvements on increasing midwifery service delivery can help achieve the Triple Aim for sexual and reproductive health. Midwifery care is associated with high levels of patient satisfaction.

Midwives also reduce costs because the midwifery model of care reduces use of interventions that increase costs of care. Midwifery care also improves health outcomes; midwife-led care models are associated with improvements in some system quality measures such as primary cesarean birth rate, preterm birth rate, and breastfeeding initiation rate. Examples of measures that can help inform midwifery service reform include:

- Early entry to prenatal care
- Primary cesarean birth rate
- Preterm birth rate
- Breastfeeding initiation rate
- Severe maternal morbidity ratio
- Maternal mortality ratio
- Unmet need for contraception

Delivery System Resilience

A final area to consider when examining service delivery is system resilience. System resilience is the ability of the health system to deliver high-quality and safe care despite sudden changes in demand or resources. Examples of events that change demand or resources include weather emergencies that force service closure, mass casualty events due to accidents or emergencies, or epidemics and pandemics. Including midwives on emergency planning committees will help improve system resilience because midwives understand the limitations of the systems where they work. There are multiple strategies that will help improve the resilience of midwifery services.

Strengthening the presence of freestanding birth centers provides system resilience by providing an alternative to using hospital services for low-risk births.

During the COVID-19 pandemic, some people at low risk of complications shifted to birth outside the hospital, which preserved hospital resources to care for the ill. Midwives play a bigger role in care in birth centers than physicians do, so policies that restricted midwifery services prevented health systems from resource-shifting to preserve hospital resources. To maximize system resilience, freestanding birth centers need to be fully incorporated into the state maternal health system. The siloed system in place during the COVID-19 pandemic resulted in layoffs for midwives who worked in hospital settings while midwives who worked in out-of-hospital settings experienced increased workloads. Another example of the siloed system during the COVID-19 pandemic was the inability of midwives to accept patients whose insurance did not include coverage for birth center care. Addressing the inconsistencies of reimbursement across birth settings and strengthening the relationships between birth centers and the rest of the health system would improve resilience for future emergencies.

Fully incorporating midwives into the state's telehealth system is another strategy to build resilience. During the COVID-19 pandemic, states expanded eligibility for telehealth systems which allowed midwives to be reimbursed for these services. Midwives adapted to the use of telehealth and most midwives would like to continue to use it. As we return to pre-COVID-19 policies, midwives in some states will have limited ability to use telehealth services, reducing the capacity of midwives to provide care. Making changes to telehealth systems now can help states be prepared for the next emergency.

Health Workforce

The health workforce includes all people who are engaged in actions with the primary intent to enhance health. This includes physicians, nurses, pharmacists, midwives, physical therapists, occupational therapists, speech therapists, respiratory therapists, etc. When providing care, midwives collaborate with many other health workers to achieve optimum outcomes for the populations they serve. However, the work of midwives remains distinct from other health workers because midwives are trained to provide the midwifery model of care.

The midwifery model of care is defined by the hallmarks of midwifery. First and foremost, among the hallmarks of midwifery is the recognition, promotion, and advocacy of menarche, pregnancy, birth, and menopause as normal physiologic and developmental processes. Midwives are trained in the non-intervention of physiologic processes in the absence of complications. This perspective on care informs midwives' practice including the client education they provide and their clinical decision-making.

Measuring the Midwifery Workforce

One challenge to measuring the size of the midwifery workforce is selecting the data source that can provide the most appropriate information for your purposes. There are three main sources available: certification data, licensing data, or billing data. Understanding the limitations can help ensure the data source used will provide an accurate number.

The American Midwifery Certification Board provides updated counts of all board-certified midwives by state or territory three times per year. This number may over-estimate the number of midwives who are providing services in a state because it includes all certified APMs regardless of whether they are in clinical practice. Midwives may remain certified but be working in fields such as academia or administration.

State licensing boards can provide updated lists on the number of midwives with active licenses in the state. These data are useful for measuring the number of midwives available to provide services in any individual state. Licensing data may not be appropriate when measuring multiple states because midwives who hold multiple licenses may be counted twice. Addresses associated with licenses may represent midwives home address rather than a work location.

The National Provider Identifier is a number given to every billing provider in the health system to track their work as it moves through electronic data systems. Because the data is national, every midwife will have only one number and all midwives who bill a third-party (e.g., Medicaid, insurance) must have one. These data also provide the address for the work location, allowing measurement of the distribution of midwives across geographic areas.

Some common statistics to investigate are the number of midwives per 10,000 population and the annual number of graduates per 100,000 population. The number of health workers

per 10,000 population is the most reported statistic internationally and can provide a good starting point for understanding area resources. Assessing the annual number of graduates per 100,000 population can paint a picture of the growth or decline of specific occupations. Because the fertility rate is different in different communities, reporting the number of midwives per 1,000 births is another useful statistic.

The downfall of midwife per population statistics is that they do not consider accessibility, equity, quality, and efficiency. When assessing the distribution of midwives, it is important to consider the imbalances in geographical representation, institutions where they work, services they provide, and the demographics of both the midwives and the populations midwives serve.

State policies that restrict midwives from working independently may contribute to workforce imbalances by concentrating the midwives in midwife-friendly hospitals or health systems. This imbalance may be seen by comparing access to midwives in urban and rural (metro and non-metro) communities or other population subgroups. State policies that prevent midwives from admitting patients to the hospital may result in midwives concentrating in outpatient settings or working non-clinical jobs rather than attending births. This imbalance may be seen by the low number of midwife-attended births per midwife in the state. A final imbalance can be caused by state policies that fail to include midwives in state insurance programs. This imbalance can be seen when there are differences in the proportion of births that are midwife-attended based on the primary payer for services.

Growing the Midwifery Workforce

Multiple scholarly articles have demonstrated that states that allow midwives to practice independently have a larger midwifery workforce. In these studies, independent practice was defined simply as no need to obtain a written practice agreement with a physician. A more complete analysis of the distribution of midwives revealed that two other state policies act as either a facilitator if they provide midwifery independence or become a workforce barrier if they restrict midwifery practice. The first is Medicaid reimbursement policy. Providing full reimbursement to midwives appears to be a facilitator for having a larger midwifery workforce. The second is ensuring midwives have independent hospital admitting privileges.

When predicting future growth in the midwifery workforce, it is important to consider the full life cycle of a midwife. This includes the time it takes to educate and prepare a midwife

to practice and the number of years a midwife remains in practice. The American Midwifery Certification Board reported 806 new midwives were certified in 2022, but because midwives left the profession the midwifery workforce only increased by 485 midwives. The major challenge to increasing the number of student midwives educated each year is the availability of preceptors.

Expanding the midwifery workforce will require policies that make it easier for prospective midwives to complete their education and policies that make it easier for midwives to remain in practice.

One way to make it easier for prospective midwives to complete their education is to build midwifery education programs. Currently, not all states have a midwifery education program. Midwives in states without midwifery education programs spent more years working as nurses before beginning their midwifery education program, which reduced the number of years they could work as a midwife. Another option is for states to adopt Certified Midwife licensing. Certified Midwives are master's prepared but are not required to complete a nursing program before beginning a midwifery education program. This is an important strategy as the American College of Nurse-Midwives student midwife survey revealed that about one-quarter of midwifery students report that they only became nurses to be eligible for midwifery education. Both strategies would allow midwives to enter the profession earlier, increasing the number of years they could work as midwives.

Another way to make it easier for prospective midwives to complete their education is to invest in midwifery preceptors.

A shortage of preceptors is the major bottleneck for midwifery education and the main limitation to expanding the capacity of existing midwifery education programs.

Without enough preceptors, there are not enough people to train new midwives. Some preceptors now require student midwives to pay for precepting, increasing the costs of midwifery education for the student. One strategy for increasing the pool of preceptors is

state incentives such as a tax credit or allowing universities to include preceptor payment as part of student fees. Investing in midwifery education needs to include building education programs and investing in preceptors.

Retaining the Midwifery Workforce

Retaining the existing workforce is vital component of growing the workforce and increasing access. Efforts to increase the number of people entering the midwifery profession will be squandered if people are leaving the profession prematurely. The American Midwifery Certification Board reported that almost a quarter of midwives are not working in the discipline of midwifery and up to 30% of those certified report not working in clinical practice 5 years after initial certification.

Common reasons for leaving practice include unsupportive work environments; work-life balance; the schedule, that oftentimes is unpredictable and/or includes nights, holidays, and weekends; burnout; and lack of compensation. Most commonly, midwives who leave clinical midwifery practice remain working in the healthcare sector or leave the workforce completely. People who leave the workforce completely oftentimes report family responsibilities, such as childrearing. People who have left midwifery practice but stayed in the workforce frequently work as registered nurses, despite having advanced practice training. This transition can be the result of job opportunities in their geographic area and work-life balance. In the context the recent nursing shortage and resulting financially incentives for nurses, registered nurses can oftentimes earn as much as a midwife.

Based on these findings, we suggest policy makers and midwife advocates invest in the following initiatives to retain the midwifery workforce. Programs that assist new graduate midwives to transition to practice can help address the large proportion of people who report not practicing 5 years after initial certification. Re-entry to practice programs that include clinical and didactic teaching for people who have taken time away from clinical practice is a strategy to re-engage a portion of the workforce who already has training and experience. Policy makers can allocate funds for existing education programs to offer these programs free of charge with a commitment to participate in the midwifery workforce upon completion. Innovative staffing approaches, such as hospitalist models and use of locum tenens for staffing, can also help retain the midwifery workforce by improving schedules and work-life balance.

State and national policies that support unrestricted practice have the potential to increase opportunities for midwives to work throughout the United States and maintain their skills. Autonomous practice authority also has the potential to improve practice environments, thereby reducing burnout. Policies that support equitable reimbursement and compensation commensurate with the training required and the inherent strain and schedule of providing perinatal care will also contribute to retaining midwives.

Health Information Systems

In the age of data-driven decisions, information is the foundation of decision-making across health systems. Reliable information is key for policy development and implementation, health research, health education and training, service delivery, financing, and governance and regulation. Health information systems collect data, analyze the data, evaluate its quality, relevance, and timeliness, and transform it into information for decision-making. Health information systems can also provide alerts, support patients, support health facility management, participate in planning, and carrying out research, produce trend analyses, provide information for reporting, and reinforce the communication of challenges occurring in healthcare.

In the current health information system, midwife data is not accurate and reliable. Much of midwife work is attributed to physicians resulting in under-reporting of the work of midwives.

An example of this is the under-reporting of midwife-attended births on birth certificates. This makes health planning difficult because the work of each provider group is not accurately measured and therefore needed workforce sizes cannot be predicted.

Midwifery data accuracy and reliability within the health information systems is a policy issue because policy is a major driver of the inaccurate reporting of midwifery work. In the 1980s, when nurse-midwives were first utilized for independent patient care, some states created policies that recognized midwives as independent providers while others restricted midwives to practice under the authority of a physician. Surveys of midwives from the 1990s found that midwives in states that restricted their practice were given as much responsibility as midwives in independent states, but that they recorded their work differently. Where midwives were restricted from receiving full reimbursement, they billed under the physician's name. Where midwives were restricted from independently prescribing, they called-in prescriptions under the physician's name. Where midwives were restricted from admitting patients, they had physicians co-sign their hospital charts. Each of these practices was adopted to help midwives and physicians comply with restrictive state policies but resulted in data that attributed the work of midwives to physicians.

Midwives and physicians are still attributing the work of midwives to physicians to accommodate outdated state policies. Physicians are still co-signing midwives' patient charts in states that restrict midwives from admitting patients. This policy work-around not only results in inaccurate data but is also inefficient because it requires two health providers

to complete the work of one. Midwives are still billing under the physician's name in states that adjust Medicaid reimbursement for midwives, though now they may use a category of billing that identifies midwifery work as "Incident To" the work of the physician. This policy workaround results in underestimating the number of medical claims submitted by midwives. Midwives can still order prescriptions under the physician's name.

Improving the accuracy and reliability of midwifery data in the health information system requires removing the policy incentives to attribute the work of midwives to physicians. States have opportunities to increase the accuracy and reliability of health information systems by de-implementing the following policies:

- Adjusting reimbursement rates for midwives
- Allowing private insurers to reject midwives from their plans
- Restricting midwives from admitting patients to the hospital
- Requiring midwives to have a physician co-sign prescriptions

Essential Medications

Access to essential medicines is vital for optimal care for patients. Examples of essential medicines for maternal health care include contraceptives, oxytocin, narcotics for labor pain management, magnesium sulfate, RhoGAM, dexamethasone, nifedipine, and folic acid. Access is measured in terms of the availability and affordability of essential medicines. When considering access to essential medicines, supply chain availability and prescriptive authority need to be considered. In the context of midwife policy, medicines are generally available, but midwives are not a route of access for these medications. Access to essential medications is a policy issue because state policies determine midwives' prescriptive authority.

The federal government is working to ensure these essential medications are available through programs such as the Affordable Care Act. For example, insurance plans in the Health Insurance Marketplace must cover contraception and counseling for all clients. Though family planning is categorized as a mandatory benefit, federal policy does not define exactly what must be included. States can decide what medications they will cover with Medicaid and can implement cost controls, such as limiting medication quantity, requiring the use of generics first, and having a preferred drug list. Policies such as these restrict all prescribers, including midwives, from providing access to essential medications.

Midwives face additional challenges when states continue to enforce restricted prescriptive authority that was adopted during the 1980s and 90s. Restricted prescriptive authority, requiring a midwife to obtain a written practice agreement with a physician to prescribe, was a strategy that allowed fast adoption of advanced practice nursing by using existing policies that allowed physicians to delegate authority to nurses. The main problem is that requiring midwives to obtain a written practice agreement with a physician limits the growth of the midwifery workforce because new midwives can only enter practice when a

physician desires a midwife collaborator. More importantly, this prevents midwives from opening clinics in communities without physicians.

Some states have de-implemented many of the restrictions on midwifery prescriptive authority but retained restrictions on prescribing narcotics. This occurs when prescriptive authority for midwives is granted in the same statute as other advanced practice nurses. Unlike other advanced clinician professions, midwives' list of essential medications includes narcotics because they are prescribed for labor pain management. Narcotics are an essential medication for pain management in hospitals without 24-hour on-site labor anesthesia. Another essential medication for midwives is mifepristone to manage ectopic pregnancy and miscarriage. Mifepristone may be used as part of an abortion regimen, so states with broad abortion restrictions for midwives can inadvertently prevent the lifesaving use of these essential medications.

Providing midwives with independent prescriptive authority for all the reproductive health essential medications will increase access to reproductive health care.

States have opportunities to increase access to essential medications by de-implementing the following policies:

- Requiring a written practice agreement for midwives to prescribe any medications
- Restricting midwives from prescribing narcotics
- Restricting midwives from prescribing mifepristone

Health Financing

There is a cost to ensuring the human resources and supplies necessary for high-quality maternity care are available. In the United States, most maternity care financing is provided by private insurance or public health insurance plans. The Affordable Care Act sets national standards for covered services, but regulation of health insurance products is overseen by the state. Because of this, each state is a separate insurance market with different products and different costs.

Private insurance is most often accessed through an individual's employer. The proportion of births with private insurance payers varies by state and is related to the overall economic landscape. Because states set the regulatory requirements for private insurance companies, state insurance policies can have an impact on access to midwifery services. For example,

states can prevent insurance companies from discriminating against midwives or refusing to cover midwifery services. States can also require private insurers to contract with birth centers where they are available.

Medicaid is a form of public insurance that is the primary payer for just under half of all births in the United States. Federal regulations in the 1980s required states to expand access for Medicaid during pregnancy for individuals with an income up to 133% of the federal poverty rate. Unlike Medicare, Medicaid is managed by states and is subject to the same variation as other state health policies. Some states expand access to Medicaid to ensure access for workers who receive low wages. Some states require individuals to apply and receive approval for Medicaid before they can access maternity services while other states allow providers to be reimbursed for prenatal care provided before Medicaid approval (called presumptive eligibility). Some states allow individuals to remain on Medicaid for 12 months after birth while others allow only a few weeks. Each of these state policy decisions affects access to all healthcare providers, including midwives, and the type of care that can be accessed.

Another challenge all providers face with Medicaid is the low rate of reimbursement for services. In some states, the costs of the care given are higher than the payment received by Medicaid for providing the service. Midwives face an additional challenge when states adjust reimbursement for care provided by midwives. States may adjust midwifery reimbursement anywhere from 75% to 98% of the amount provided when a physician is the billing provider. Adjusting midwife reimbursement can make independent midwifery practices financially unsustainable. To overcome this challenge, midwives will work in an office where their services can be billed under a physician's name.

In some states, there is resistance to changing the billing systems because there is an assumption that costs would increase if midwives received the full reimbursement. This assumption has two major flaws, so the assumption of savings with an adjusted reimbursement rate should be challenged. The first flaw is that many midwives and physicians are already using billing strategies that ensure midwifery reimbursement at the full physician rate; there may be negligible costs to simplifying the process of midwives receiving full reimbursement. The second flaw is that states that adjust reimbursement for midwives have a smaller midwifery workforce and, because of the small midwifery workforce, lose the cost-savings that is associated with the lower rate of intervention when the population receives midwifery-led care.

Ensuring midwives receive reimbursement that covers the costs of doing business is essential for any state that desires to build the midwifery workforce.

States have opportunities to include midwives in the health financing system by de-implementing the following policies:

- Adjusting the Medicaid reimbursement rate for midwives
- Allowing private insurers to exclude midwives from the provider panel

Leadership and Governance

Health systems are designed and implemented by the community leaders who are appointed, elected, or hired to run them. Health system leaders build the system by ensuring strategic policy frameworks exist and are combined with effective oversight, regulation, and attention to accountability. Each state adopts its own leadership and governance structure. Ensuring midwives are well integrated into the leadership and governance of the state health system is key to ensuring policies are implemented in ways that expand, rather than restrict, access to midwives.

Midwives should be represented on the state licensing board and other state maternal health advisory boards. Often, the composition of these boards is defined in state statutes. If midwives are not currently included, nurse-midwives may apply to fill the nursing role as a temporary solution. The long-term goal should be to ensure midwives' voices are represented on the boards that regulate their practice.

State maternal health leadership also includes state quality committees such as a perinatal quality collaborative, maternal mortality review committee, or Alliance for Innovation on Maternal Health team. These committees have different roles within states, but generally act as information sources for policy makers, health department administrators, and hospital leadership. If midwives are not represented on these committees, it is unlikely the committee recommendations will include de-implementing state midwifery restrictions that hinder quality improvement efforts. State committees are formed differently in each state; midwives may need to be appointed, may need to submit a letter of interest, or may be able to be a drop-in volunteer. The state health department should be able to help midwives identify the state quality committees, whether midwives are represented, and how midwives can secure positions on these advisory boards.

State schools of nursing are often viewed as leaders of nursing in a state. If nurse-midwives are not represented on the faculty the school, the state's academic leadership may not be aware of the unique policy challenges midwives face. Because deans of schools of nursing

are frequently asked to provide information about nursing issues to the legislature, they can be strategic allies in achieving policy reform. Public state colleges and universities can also be a strategic ally to increase the midwifery workforce in states without a midwifery education program. These institutions are tasked with building the health workforce and have the infrastructure to manage state investments in workforce growth such as state-funded grants for student midwives.

Hospitals and hospital systems provide local or regional health system leadership and governance. Where midwives are restricted from serving on hospital medical staff, midwives' perspectives are not reflected in the hospital decision-making process. In some states, hospitals are not allowed to let midwives serve on medical staff or admit patients. In these states, hospitals may be strong allies for policy reform because policy change could allow the hospital to open a midwifery service.

Strong state midwifery associations are key to the integration of midwives into the health system.

A strong state midwifery association provides an easy point of contact for interested parties who want to work with midwives to achieve policy change. When the state midwifery association is in regular communication with other members of the health system, they may be contacted about upcoming policy or regulatory changes, provided opportunities to present to state boards or committees, or to provide information to the legislature. A strong state midwifery association provides an avenue for communication about advocacy strategies, expanding the reach of the advocacy efforts.

SETTING THE POLICY AGENDA

To achieve policy change, midwives must participate in setting the policy agenda. The policy agenda refers to the collection of issues that policy makers agree to work on. The policy agenda does not include all issues and demands that exist in a community. This is because policymakers have the power to set priorities. Policy makers have both the power to decide which issues to address and the power to decide what strategies will be used to address the issues.

Setting the policy agenda is a political process. In this context, political refers to the activities that define group decision making for a community. All groups have formal and informal structures that are followed for decision making. For health policy, the formal structures include laws or regulations that define how an issue is brought to the community for a decision, the process for contributing public comment on the decision, the timeline for decision making, and the process for making the final decision. The informal structures include the mechanisms by which individuals and groups use their power to influence decisions through advocacy and negotiating with other interested parties.

Introduction to Kingdon's Multiple Streams Framework

Kingdon's Multiple Streams Framework is a tool for understanding policy agenda-setting, that is, how to achieve policy change. Kingdon believed there are many different solutions to any policy issue and was interested in why one solution was selected over the others. For our purposes, why does a state choose to incorporate midwifery or exclude midwifery from the health system? Kingdon's framework proposed that windows for policy change open when problem streams, policy streams, and politics streams align.

Figure 1 Kingdon's Multiple Streams Framework

Problem Stream

Kingdon believed that problems are inherently ambiguous. Any situation is defined differently by different community members because they have different levels of knowledge, different perspectives, and different interests in any issue. Kingdon recognized not only are there different interpretations of situations, but an understanding of the situation can shift as individuals have new information or as resources change. Because of this, Kingdon stated that for a policy agenda to be set, there must be agreement that a situation is a problem and there must also be a common definition of the problem.

Policy Stream

The policy stream reflects the agreement on a policy solution to the defined problem. Because problems are ambiguous, multiple policy options will be proposed as solutions. Not all policy options will be acceptable to all interested parties. Some policy options will not be feasible due to costs or timeline. Some policy options will fail to get support because they violate one of the population's core values. Kingdon stated there must be widespread support for a particular policy option to address the problem or the policy agenda is not set.

Politics Stream

Politics is the way we arrive at the rules, processes, and systems we put in place. Politics is a dynamic system of relationships between individuals and communities based on power. Power comes from the unequal distribution of authority, status, and resources. For Kingdon, the politics stream represented the intersection of the power, influence, and pressure that determine what problems will be acted on. This is sometimes described as the political "mood". Kingdon's main point about the politics stream was that, to a great extent, it is out of our control when the political mood will be right for our policy change. Because of this, midwives need to be ready to act when the window opens. Once the window closes you may need to wait a long time for it to open again.

Applying Kingdon's Multiple Streams to Midwifery Regulatory Reform

Midwives are the only group of community members who can bring the midwifery perspective when agenda-setting. Other healthcare workers cannot speak to the problems midwives face when working in their communities.

Other health care workers may not understand how a policy solution will help or hinder midwives' ability to contribute to achievement of community health goals. Midwives participate in agenda-setting through activities such as presenting to state boards, writing opinion articles for newspapers, participating in media interviews, and speaking to legislative committees.

One challenge midwives face when agenda-setting is that it is difficult to get interested parties to agree that the current midwifery regulatory environment is a problem. It may be easier to get interested parties to agree that midwifery regulatory reform is a potential policy solution to an already identified problem. To do this, midwives take a population health perspective and propose midwifery regulatory reform as a potential policy solution to problems such as lack of access to care or poor health outcomes. This strategy can be effective in states where there is already widespread agreement that the current maternity care system is a problem. Many states have begun making maternity care reform, demonstrating that the political mood is positive for maternity care reform. This strategy may also be easier because midwifery regulatory change can be offered as a small part of a larger package of reform to increase access to care.

The rest of this section contains examples of ways to frame midwifery regulatory reform as a potential policy solution to different problems states may be facing.

Frame One: Health System Efficiency

Health system efficiency refers to the cost-effectiveness and value for money of the care provided. At its most simple, health system efficiency may be described as the ratio of the value of health resources used to the value of the health outcomes achieved. The most efficient health systems achieve the best health outcomes while using the fewest resources, usually measured by total costs. In contrast, inefficient health systems provide

low-value care. This may mean the care has the same costs with poorer outcomes, or that it achieves the same outcomes but at a higher cost.

Policymakers may be interested in health system efficiency for several reasons.

1. Low-value care may mean that the population has poorer health outcomes than could be achieved with higher-value care.
2. Inefficient treatment means more resources are used per patient, so the health funds provide care for fewer people.
3. Inefficient health systems use more money than is necessary to achieve good outcomes, which means less money is available for transportation, education, or other community needs.

Incorporating midwives into the health system improves health system efficiency in several ways.

1. Midwives provide high-value care. Midwives achieve equivalent health outcomes while using fewer high-cost services such as inductions and cesarean surgery.
2. A health system with midwives allows physicians to focus their efforts on people with high-risk pregnancies. This is an efficient use of the health workforce.
3. Midwives can be educated in two-three years post-bachelors, allowing rapid scale-up of the workforce.

Challenges to the Health System Efficiency Frame

When economists talk about health system efficiency, they are generally taking a societal perspective, which means they are looking at all the costs associated with health care, no matter who pays them. While policymakers do need to think from the societal perspective, it is not the only perspective they may take. For example, an inefficient health system may be preferred by hospitals or providers because the higher costs of care result in higher revenues. Inefficient health systems may also be acceptable to some policymakers because they allow some members of the population to receive preferential access to healthcare resources.

When using the health system efficiency frame, consider building arguments from the perspective of the state Medicaid system. This can be a beneficial strategy because the state contributes funds to the Medicaid system and so improving the efficiency of care paid by the state will save the state money.

Frame Two: Health Equity

Health equity is achieved when everyone has a fair and just opportunity to attain their highest level of health. When health services are not equitable, health disparities result.

Health disparities are preventable health differences in the population. National efforts to achieve health equity are focused on the disparities experienced by four population subgroups: residents of rural areas, people living on a low income, people from racialized groups, and people whose sex or gender identity puts them at risk for discrimination. Achieving health equity requires building an equitable health system. An equitable healthcare system ensures all people can access care.

Policymakers may be interested in health equity for several reasons.

1. Inequitable health systems place the burden of poor outcomes on specific groups of people.
2. Inequitable health systems result in health disparities.
3. Equitable health systems are viewed as a moral imperative.

There may be several opportunities to increase health equity by reforming midwifery regulation.

1. Adopting midwife Medicaid parity improves the sustainability of midwifery practices that provide care for low-income communities.
2. Ensuring midwives can practice autonomously (no written practice agreement), allows midwives to provide services in communities that have no physicians.
3. Midwives are primary care providers so can help a state achieve equity in access to contraceptive care, primary care visits, menopause, and sexual health care.

Challenges to the Health Equity Frame

Achieving health equity requires the removal of structural bias, social inequities, and racism. Though midwifery regulatory reform can improve equitable access to care, the limited scope of midwives may cause some interested parties to consider midwives as having a small impact on health equity. If this occurs, midwifery regulatory reform may not be the priority for interested parties who seek changes that will have a larger impact.

When using the health equity frame, consider both the measures of health outcomes (such as preterm birth) and the measures of access to care (such as unmet need for contraception). It can be helpful to highlight the full scope of midwifery services to ensure

interested parties understand midwives can contribute to improving health equity for sexual health, reproductive health, and gender-related health.

Frame Three: Market Competition

In the United States, many policymakers trust the market or "free market capitalism" to ensure high-value care at the lowest possible costs. The free market is an economic system where resource supply and demand determine how resources are distributed. Within this system, individual consumers are expected to select their health care based on what provides the highest value to them. One of the key concepts of the market is competition among suppliers of health care. Suppliers who face competition for consumers are expected to produce a higher-value product.

Policymakers may be interested in market competition for several reasons.

1. Lack of market competition results in higher prices for health care.
2. Lack of market competition results in lower-quality care.
3. Lack of market competition reduces consumer options for addressing healthcare needs.

Some states have opportunities to increase market competition by integrating midwives into the maternal healthcare system.

1. Adoption of independent midwifery (no written practice agreement) ensures midwifery supply is matched to consumer demand for midwifery care, not physician demand for midwife employees.
2. Providing Medicaid parity for midwifery care increases the competition to provide care for people who use Medicaid insurance.
3. Ensuring midwives can practice independently from physicians includes three policies – independent practice, equitable reimbursement, and independent hospital admitting.

Challenges to the Market Competition Frame

Opponents to midwifery as market competition to physicians may bring arguments that midwives are not physicians' equal in medical skill and so cannot provide market competition. It may be helpful to highlight the scope of midwifery and focus on the discussion on consumer access to the types of services midwives provide and the variety of settings where midwives could work if they were not tethered to physicians by a written collaborative agreement.

Frame Four: Health System Resilience

Weather emergencies, pandemics, and mass casualty events increase demands on local hospitals. However, the maternal health system cannot stop operating during or after an emergency.

Communities need a flexible maternal health system that can accommodate temporary hospital closures and increased community needs for care. Incorporation of midwifery into the health care system can provide flexibility because midwifery-led birth centers provide non-hospital-based maternity care for people at low risk of complications.

This can help reduce the strain on hospitals during emergencies. Midwifery-led birth centers can also act as a health outpost for communities whose local hospital closed their maternity service.

System resilience also requires having a sustainable health system, including the workforce. The US obstetrical workforce shortage is worsening. The March of Dimes reports that the number of counties that are maternity care deserts (no services) is increasing. Midwives can be part of the solution to address the shortage. Some states have opportunities to increase the sustainability of their healthcare workforce through midwifery regulatory reform. For example, licensing Certified Midwives reduces the total time of training for future midwives by removing the need to first train as a nurse. Another example is removing the requirement for a written practice agreement to allow midwives to remain in communities that have lost their maternity hospitals.

Policymakers may be interested in health system resilience and sustainability for several reasons.

1. Closure of rural hospital maternity services results in lack of access to maternity care for local communities.
2. Shrinking obstetrical workforce may increase rates of poor maternity outcomes and/or contribute to disparities in poor maternity outcomes.
3. Regular updates to the all-hazards emergency plan should include plans to meet the needs of pregnant and birthing people and newborns.

Some states have opportunities to increase the resilience and sustainability of their health care systems by:

1. Removing requirements for written collaborative agreements allows midwives to operate midwifery-led birth centers that increase maternity system resilience.
2. Ensuring full Medicaid parity for midwifery-led care ensures the sustainability of the midwifery-led services that are key to maternity system resilience.

3. Protecting the right of midwives to admit their patients to the hospital removes unnecessary requirements for physicians to duplicate the work of midwives.

Challenges to the health system resilience frame

Opponents may argue that relying on midwives to address shortages will result in a two-tier system where some community members get "lesser" care provided by midwives. This argument is built on the faulty assumption that midwifery care is lower in quality or value than physician care. National and international evidence is conclusive that midwives provide high-quality care and that the care provided by midwives is high-value and cost-effective.

Advanced practice nursing advocates join ACNM Government Affairs on Capitol Hill to promote passage of the Improving Care and Access to Nurses (ICAN) Act

ENGAGING INTERESTED PARTIES

Midwives need to be present and visible to their local and state decision-makers. There are many ways midwives can increase their visibility. Some ideas include joining local and state boards, participating in state or hospital committee meetings, and joining professional organizations for midwives and healthcare professionals. Midwives should also be present and visible to other community members with interests that align with midwives. Interested parties need to be aware that a midwifery policy problem exists for them to become engaged with it. By increasing the public presence of midwives, more information will be spread about who midwives are, what they do, and how policy problems affect the state.

This section of the toolkit was created for midwives to engage interested parties in midwifery policy problems. These policy problems can occur at the hospital, local, state, and national levels. Engaging interested parties is how midwives can influence the problem stream and policy stream in Kingdon's Multiple Streams Framework. Engaging interested parties also helps build a mood for policy change that is essential to open the policy window. Over the next few pages, you will learn how to use tools to identify and prioritize the interested parties who can help midwives achieve policy change. This will prepare you to make the best use of the limited time during a policy season.

Potential Interested Parties

Members of the Legislative Health Committee
Members of the Legislative Commerce Committee
Department of Health Title V Director
Department of Health Title X Director
State Medicaid Director
State Department of Health Primary Care Office
State Department of Health Rural Health Office
State Board of Nursing/Midwifery
State Board of Medicine
State Board of Pharmacy
State Maternal Mortality Review Committee
State Maternal Child Health Committee
State Insurance Organizations
State Hospital Association
State College of Obstetricians and Gynecologists
State Medical Association
State Advanced Practice Nursing Associations
State Political Organizations
Deans of Schools of Nursing or Health Professions
Deans of Schools of Medicine
Hospital Chief Nursing Officers
Hospital Perinatal Services Director
Hospital Chief of Obstetrics
Rural Health Clinic Directors
Federally Qualified Health Center Directors
State Workers Union Leaders
Organized Community Groups

Identifying Interested Parties

Interested parties are people or organizations with a vested interest in the policy being promoted. As you develop your policy plan, identify interested parties, experts, individuals, and organizations who are connected to the issue. These people can aid in policy development and can provide additional public support for the proposed policy change.

When identifying key interested parties, it is important to consider their perspectives and needs and to build relationships around those. This helps ensure that policy changes your group recommends are relevant to their needs and will improve their situations. Having a diverse group of interested parties will allow collaboration that produces equitable and inclusive policies.

The list of relevant interested parties will depend on your local community. For example, some communities will have local chapters of La Leche League and other local parent groups. The list of relevant interested parties will also depend on the policy problem you are trying to address. For example, hospitals may have an interest in midwifery policies that increase the productivity or profitability of a hospital. Depending on the policy being produced, many different types of interested parties will be needed. It is important to identify the goal of the policy and then consider the different levels of involvement with key interested parties approval and implementation.

Interested Parties Analysis

Interested parties' analysis is an important step in which information is gathered and analyzed to determine which interested parties should be involved when you are developing or implementing a policy. Analysis should include interests related to the problem and the policy solution, the position for or against a policy, possible alliances with other interested parties or influential groups, their interests related to the policy, and how they could affect the policy process.

Sources of Information

Newspaper articles

State Reports

Political Platforms

Organization annual reports

State Budget Reports

Opinion Polls

Creating a general list of interested parties should be a group activity. Begin by listing all the potential interested parties in your state, and why they would have an interest in your policy change. Once you have a full list, work as a team to identify the priority parties. It can be helpful to get outside opinions to help you identify additional interested parties and to help you prioritize the parties for contact. The following is a brief example of how to prepare your initial list of interested parties.

Sample General List of Interested Parties

Interested Parties	Reason Chosen	Contact Priority
State Legislature Health and Human Services Committee	They have jurisdiction over bills related to health care. We need their support to get the bill passed.	High
Title V Director	Title V funding is used for maternity and newborn care. The director makes recommendations about policy changes that can improve maternal and child health.	High
Deans of Schools of Nursing	The Deans have been working with the legislature to address the healthcare workforce shortage. They frequently provide testimony to committees and legislative staff reach out to them to ask questions.	High
State Hospital Association	The policy change would allow hospitals to use midwives as laborists.	Medium

After you compile the list of interested parties, it is time to gather and organize information about them to help you make data-driven decisions about what policy strategy and advocacy strategies to use. Learning about your interested parties will also allow you to interact with their representatives more effectively and increase the backing and support for a policy. As you build your list of interested parties, begin to use public sources of information, such as their website, to learn more about them. The main information to gather about each interested party is their knowledge of the policy problem and potential policy solutions, their position on your policy proposal, and their resources to support or oppose your policy solution.

The information you gather can be organized into a simple characteristic table. A characteristic table provides a brief description of each interested party's characteristics. Using a digital table such as a google document can allow all team members to contribute to – and see updates to- your table. A sample characteristic table is provided below. This sample table can be adapted to fit your project's needs.

Sample Interested Party Characteristic Table

Interested Party	Level of Knowledge	Current Position	Interests	Existing Alliances	Resources	Power
Chair of the State Legislature Health and Human Services Committee	Low	Neutral	Wants to be seen as advancing health in the state before next election	Works closely with the medical association president	Can introduce the bill	High

Once you have completed the characteristic table, you can begin analyzing the information you collected. Assessing the parties' overall level of knowledge about the problem allows

you to make quick assessments about needs for education about the problem and potential solution. Assessing the overall current position can help you prioritize parties for communication. Assessing the parties' interests can help you identify common objectives that can be achieved with policy change. Assessing the existing alliances can help you identify a pathway for meeting with hard-to-reach parties. Assessing the resources and power can help determine the overall strength of support or opposition.

Identify Common Objectives

Identifying common objectives is an important step to take when working with interested parties. If team members and interested parties have common interests and objectives, the likelihood of success for a policy increases. When identifying a common objective, midwives should consider the population-level result, which often means thinking about population-level health outcomes. The state chartbook, which is available to ACNM members, provides you with data for six population-level health outcomes for each state. Examples of population-level results are increasing the size of the maternity workforce or reducing disparities in access to care. The state chartbook provides you with data about the size of your state's maternity workforce and data about three potential population-level disparities.

It may be possible to identify common objectives by reviewing the interested parties' website, published documents, or other public data sources. For some interested parties, it may be necessary to request a short meeting. Below is a sample script for conducting a brief (15-minute) meeting with an interested party to help identify common objectives. This meeting is best characterized as an interview because the objective of the meeting is to ask the party about how their organization is affected by the policy problem and the potential policy strategies.

Sample Interested Party Interview "Script"

We are from the state affiliate of the American College of Nurse-Midwives, and we are exploring the opinions of healthcare leaders in our state who are interested in maternal health care. We know your work affects maternal health care, so it is critical for us to obtain your opinion and the opinion of your organization. We are conducting these interviews to understand general ideas about using midwives to address the maternity care shortage. We would like to ask you a few specific questions about your opinion regarding barriers to scaling up the midwifery workforce.

1. Are you aware that our state has one of the smallest midwifery workforces? If so, how did you hear about this?
2. What do you understand about the work of midwives?

The American College of Nurse-Midwives represents Certified Nurse-Midwives and Certified Midwives. These midwives are educated in graduate-level programs and are the midwives who attend 90% of the midwife-attended births in the United States. Midwives can provide care for people experiencing essentially healthy pregnancy and birth autonomously and are educated to participate in collaborative care teams for people with health and medical

issues. Most births attended by these midwives are in hospitals, and midwives are educated to manage the induction of labor and to work with anesthesiologists to ensure their clients can have an epidural during labor if desired.

3. What are the potential benefits to you and your organization if we expand the midwifery workforce in our state?
4. What are the potential disadvantages to you and your organization if we expand the midwifery workforce in our state?

Expanding the midwifery workforce is one strategy to address the shortage of maternity care workers. A major challenge to expanding the midwifery workforce is that Medicaid adjusts reimbursement when care is provided by a midwife. Practices receive 75% of the fee when a midwife, rather than a physician performs care. This financial disincentive makes it difficult for private practices and hospitals to afford hiring midwives and contributes to the ongoing shortage of maternity care.

5. What would be the potential benefits to you and your organization if Medicaid stops adjusting the reimbursement rate for midwives?
6. What are the potential disadvantages to you and your organization if Medicaid stops adjusting the reimbursement rate for midwives?

ACNM President Heather Clarke, DNP, CNM, APRN, LM, FACNM, NPWH CEO Heather Maurer, ACNM Director of Government Affairs Amy Kohl attending a Black Maternal Health event at the Department of Health and Human Services in Washington, D.C.

ADVOCACY STRATEGIES

Advocacy is defined as the actions taken to support or defend a particular cause. Advocacy plays a major role in influencing the adoption of new policies because advocacy work helps build consensus that there is a problem (the problem stream) and that there is a solution (the policy stream). Midwives are already experts at being advocates for their patients when providing clinical care. These skills can be transferred to advocating for policy change.

Successful policy advocacy involves influencing a variety of interested parties to support your policy issue. This will include the collaborative work you completed to define the problem and select the solution for your community. It will also include educating and influencing the people in decision-making roles such as legislators, administrators, or chairs of state boards. This section of the toolkit will take you through the steps of building your advocacy strategy. Your first steps will be to identify your goals and to understand the people and groups that need to be influenced. Once you know your goals and your audience, you can use this information to build your advocacy team.

Selecting an Advocacy Strategy

Step One: Identifying Your Audience

Knowing who has the authority to make the changes you want to implement will guide the direction of your project. Examples of people with authority to make change include lawmakers, insurance companies, and licensing boards. The people you are trying to influence need to actively support midwifery regulation reform and be able to implement changes. Advocating to people who cannot actively make changes will not be effective long-term. To identify your audience, use the state chartbook (available to ACNM members) to identify the location of the policy for your state.

If the policy is in a statute, this means it is a law. To change a law, you will need to convince state legislators to vote for a bill to change the statute.

If the policy is in regulation, this means the policy is set by an administrative branch authority. To change a regulation, you have two options. The first option is to convince the administrative authority to change the regulation during the next update. The second option is to convince state legislators to vote for a statute that requires a regulatory change.

Once your audience is identified, your team should identify the process of proposing changes to the authority. For example, if you are proposing a new bill, you need to know where it will be presented, who it will be presented to, and the processes that need to occur for it to be signed into law. This can be challenging for people with little legal experience; getting other people involved such as lobbyists, lawyers, and other political figures can be helpful. These people will have more experience with the legal system and will be able to ensure that all steps are completed correctly. Because many of the people who can make changes, like legislators, are not familiar with the healthcare field and midwifery, it is important to take into consideration the education that will be needed for them to comprehend the issues and proposed policies.

Step Two: Setting Policy Advocacy Objectives

Deciding on a policy to work on can be overwhelming. You may have multiple changes you would like to accomplish, and you may have more than one strategy for making the change. With so many options and different paths, it can take time to select a policy advocacy objective. Policy advocacy objectives need to be defined simply with nontechnical language so that common understanding occurs among interested parties, policymakers, and the community. Goals should be specific and have an emphasis on actions needed to achieve implementation of the policy.

It is best to set policy advocacy objectives for a political season. Each state has its own legislative calendar. You can find the calendar on your state's legislative website. Your state's political season will revolve around legislative sessions. A session is a time during which bills can be introduced and voted on. At the end of the legislative session, any bills that passed are moved into law, and bills that did not pass must be re-introduced in the next session. Between sessions, legislative committees prepare for the next season by holding public meetings to get information about potential policy changes.

When setting your policy advocacy objectives, consider the political feasibility of each policy option. If the climate is not right, no matter how much work is put into a policy, achieving change during the current session could be difficult. There are two steps to compare the feasibility of policy options by identifying the types and level of each potential policy change strategy. First complete the Allies and Opposition Matrix for each option being considered, then use the information to build a Position-Power Matrix for each strategy.

To complete the Allies and Opposition Matrix, identify the potential key actors that already support the change (core supporters), those that can be convinced to support the change (potential allies), and those that you know will oppose the change (opposition). You should be able to complete the matrix based on the information you gathered during the analysis of interested parties.

Example: Allies and Opposition Matrix

Policy Strategy	Core Supporters	Potential Allies	Opposition
Change the statute	Department of Health	Community Group Hospital Association	Medical Association
Change the Regulation	Department of Health	Department of Health Medical Association Hospital Association	
Change each hospital	Hospital Association Department of Health	Medical Association	Individual Hospitals

After you complete the Allies and Opposition Matrix, you will combine the information with information about the level of power each of the interested parties holds to complete a Position-Power Grid. To build a Position-Power Grid, place each interested party on the grid based on their current position and level of power. Do not place neutral parties on the grid until they commit to either support or opposition. An example is provided below.

Example: Position-Power Grid

	Position	
	Support	Oppose
High Power	State Legislature Health and Human Services Committee Title V Director	State Hospital Association
Low Power	Deans of Schools of Nursing	

Once the grid is completed you can see the strength of the support and opposition for each policy strategy. This allows you to compare the feasibility of each strategy being adopted during the current political season. Policy strategies are most likely to be implemented if they have more support than opposition, and if the support is from parties with high power. If a strategy has very powerful opposition, implementation of the policy change is likely not feasible. Similarly, if a strategy has only weak support the policy change is likely not feasible. If your group has adequate funds, a lobbyist can help narrow down a feasible policy.

When a policy strategy is not feasible in the current political season, you have two options. The first option is to select a different strategy that is feasible. The second option is to use the current political season to build a coalition of supporters through education and outreach. The goal of this work is to build support for policy change in the next political season.

An important part of preparing your policy strategy is identifying the advantages and disadvantages of the policy for all interested parties. The challenge is that any policy

strategy may have benefits for one interested party and disadvantages for another. An Advantages and Disadvantages Matrix will allow your team to examine the effects of the policy change clearly and transparently on all interested parties. Each row of the table should list a single advantage or disadvantage, and all the interested parties who are expected to experience the advantage or disadvantage. Use information gathered during your analysis of interested parties to complete this table. As you work to educate your community about midwifery, you will likely gather additional information about advantages or disadvantages of the policy options.

One way to use the Advantages and Disadvantages Matrix is to eliminate any options that have more disadvantages for your community than advantages, or options that only provide advantages for a single interested party. Strategies with few community-wide benefits are unlikely to receive support. Strategies that provide advantages for only a single interested party may contribute to inequity. Do not complete this step before you have a complete list of the advantages and disadvantages for all interested parties. Consider that most parties are likely to have a mix of advantages and disadvantages; take the time to include each of them.

Another way to use the Advantages and Disadvantages Matrix is to identify the ways the policy option will contribute to solving the community's problem (the problem stream). To build support for your policy change, persuasive arguments need to be made. Linking the known advantages of the policy option to the ways the advantages will help solve the problem allows you to build persuasive arguments. Using facts and figures can help people with limited knowledge of midwifery better understand what is occurring in the field and how the policy will benefit the community.

Example: Advantages and Disadvantages Matrix

Advantage	Disadvantage	Parties Affected
Increased payment to practices for services		Hospitals Private Practices with Midwives
	Increases Costs to Medicaid	Medicaid Commissioner Medicaid Managed Care Organizations
Practices can afford more providers, increasing access and decreasing wait times for visits		Health Service Users
	Increased competition for maternity services among medical care providers	Private practices that provide maternity care
Increased competition results in increased quality of services		Health Service Users Title V Office

Step Three: Build a communication plan

A communication plan is your strategy for building support for your policy change. Your communication plan should include building a common understanding of the policy problem (problem stream), and a common language to define the solution (policy stream) to build consensus. Your communication plan should include both your efforts for educating about the issue and advocating for the recommended policy change.

A good communication plan will identify the audience, the message, the messenger, and the format for communicating. The audience refers to the group who is intended to receive the message and can be as specific as a state committee or as broad as midwifery clients. The message is the information that should be communicated during this step of the plan. Be as specific as possible, especially for audiences you will communicate with more than once. The messenger is the group member who will take responsibility for that step of the communication plan. The messenger should report back to the group after the message has been communicated to help identify any changes that should be made to the communication plan. The format for communicating is the way the message will be communicated. Be as specific as possible and include the dates when communication should happen. An example is provided below.

Example: Communications Plan Worksheet

Target Audience	Message Content	Messenger	Channel/Format
Midwifery Clients	Make it easier to access midwives	Practices	State Midwifery Social Media Page – Weekly during legislative Session
State Medical Association	Streamline getting full reimbursement when your midwives provide care	Affiliate Leader	Quarterly Meeting/Report – First Thursday of the quarter (January).
Maternal Child Health Advisory Board Medicaid Commissioner	Current policy results in poor data quality, already paying full price for midwives, contributes to workforce shortage	Affiliate Leader	Public Meeting for February.

As you build the communication plan, consider both formal and informal communication strategies. Formal communication may include presenting at state committee meetings, legislative committee hearings, or to state professional organizations. Informal communication may include social media posts or information fliers posted in offices. It is helpful to include radio, podcast, or TV interviews to build a wider base of support.

Your communication plan can include a variety of formats including community events, a letter-writing campaign, or a Legislative Action Day. Community events provide a venue for members of the public to learn about and support proposed policies. Having the public support of a new policy can help create the political climate to achieve policy change.

Letter-writing campaigns can be used to write to legislators, board members, and whoever else has the power to implement the policy. For a policy to have a chance at implementation, the people with the power to make those decisions need to see that there is widespread public support for the policy change. Letter-writing or email campaigns are most effective if timed right before a vote on the policy change. Legislative Action Day is a day when members of the affiliate and other supporters visit the state capital to speak with their representatives about the importance of the policy change. Legislative action days provide an opportunity to speak directly with legislators or their staff to answer any questions they may have.

You should also consider the timelines for each audience. State boards and legislative committees will follow a calendar that defines when information needs to be submitted to be added to the agenda. You can also use the legislative calendar to ensure activities align with the timeline to move bills forward. Media organizations will have deadlines to submit editorials, op-eds, or blog posts. Podcasters may record interviews a month or more before posting. Radio and television interviews can be delayed if the editors feel something more newsworthy should be given the time. Team members can gather information about deadlines before the first planning meeting to prevent planning delays.

Advocacy Project Management

Like all projects, an advocacy campaign needs to be managed to increase the odds of success. A project management plan will help ensure that all components of the project will be addressed and that the project will be completed on time.

One of the first steps to be completed is setting a timeline. If there is an end date in mind, it can be helpful to reverse engineer the project. With reverse engineering, you start with the end date and work backwards through the calendar to identify when each step must be completed to achieve the goal before the end date. This allows you to schedule adequate time for everything that needs to be done before the deadline. All the steps of the project need to be identified and responsibilities need to be assigned. Establish milestones that indicate key steps of the project have been completed.

After the timeline has been established, the next step is to decide how advocacy will be carried out. As you build this plan, consider the resources needed to achieve each proposed step, both personnel and financial. Though the personnel may be volunteers and the costs may be covered by monetary or in-kind donations, it is important to have as accurate an estimate as possible of the resources needed for each step to help your group plan for future efforts.

The next step is to build your policy advocacy team. This team will consist of group members who are comfortable with political situations and have experience with the skills needed to complete at least one of the steps. Specific team roles to consider include organization liaisons, a communication manager, a media team, and lobbyists. Organization

liaisons can communicate the needs and visions of both groups to each other. Having a designated liaison will provide consistency of communication with organizations to improve relationships and promote better communication. A communication manager works to facilitate communication among all the different team members. They can ensure consistency of the message and ensure that deadlines are met. This will increase productivity and reduce confusion. A media team can consist of people with media backgrounds and experience such as graphic designers, social media strategists, photographers, and others. These people are experienced in producing promotional materials to build a professional image that will appeal to viewers.

Lobbyists are key members of the policy development and approval process. Lobbyists are people who advocate matters before legislators or other state/federal agencies. They are experienced in communicating with these individuals and are aware of the necessary content needed to promote new policies. They also have relationships with legislators and board members and can start the process of getting your policy introduced. Lobbyists are good resources to use for the political side of introducing a new policy. When finding a lobbyist, keep in mind that their goals need to be in line with the goals of the team. Choosing the right lobbyist for your policy can be one of the most important steps in this process.

An advocacy project manager should be appointed to keep track of all the policy efforts. The project manager will conduct the ongoing evaluation to identify if the strategy is working and where improvements can be made. Advocacy is an ever-evolving process. As the strategy is implemented, there will be some things that work and some that don't. It is important to be adaptable and willing to adjust to improve the chances of success of the project.

Advocacy Project Evaluation

At the end of the political season, your team should evaluate the advocacy project as a first step to plan for the next political season. Process evaluation asks if the steps that were planned were able to be completed. Outcome evaluation asks if the objectives of the project were met.

Process Evaluation

Evaluating the process of an advocacy project identifies any challenges the team faced. This main use of this evaluation is to improve planning for the next political season. Process evaluation can be completed during a group meeting where all team members contribute.

The first part of the evaluation is to assess if each step of the advocacy plan was completed by the deadline. Put simply, the team asks the question, "Did the project meet this milestone on time?" The second part of the evaluation is to identify why the milestone was or was not met. This is not about identifying blame, instead it should be approached with the assumption that all team members did the best they could with the resources available.

Instead, focus on identifying the resources and conditions that contributed to meeting or not meeting the milestone.

For each milestone, gather enough information to identify how strengths of the plan contributed to success and allowed the team to overcome challenges. When milestones were not met, identify some changes that could be made in the future to help achieve the milestone. Think about the resources that were available, the interested parties that were involved, the communication tools that were used, and the time provided to complete the work. If possible, identify strategies to increase the likelihood of meeting the milestone in the next political season. Example strategies may include providing more time to complete steps, increasing the size of the team, hosting educational sessions for team members, or working with other collaborators.

Outcome Evaluation

Outcome evaluation of an advocacy project identifies if the team met the overall objective. The main use of this evaluation is to determine if the project objective was met, or if more work needs to be done in the next political season. For example, if you were working to build support for policy change through education, your project outcome evaluation may consist of building a new Position-Power Grid to determine if you achieved the level of support necessary to be successful in the next political season. If you were working to pass legislation, your project outcome evaluation would be based on whether the legislation was passed.

MODEL LANGUAGE

Model Language for Equitable Midwifery Licensing and Prescribing

Arizona
A.A.C. § R4-19-505 provides a model of language that licenses midwives for independent practice. A.A.C § R4-19-512 provides language for independent prescribing.

Hawaii
HRS § 457-8.5 provides a model of language that licenses midwives for independent practice. HRS § 457-8.6 provides the language for independent prescribing.

Kansas
K.S.A. § 60-11-101 provides a model of language that licenses midwives for independent practice. K.S.A. § 60-11-104a provides the language for independent prescribing.

Maine
CMR 02-380-008 provides a model of language that licenses midwives for independent practice with independent prescribing.

New Hampshire
RSA 326-B:11 provides a model of language that licenses midwives for independent practice with independent prescribing.

New Mexico
16.11.2.9 NMAC provides a model of language that licenses midwives for independent practice. 16.11.2.10 NMAC provides the language for independent prescribing.

New York
NY CLS Educ, Title VIII, Art. 140 § 6955 provides a model of language that licenses midwives for independent practice. NY CLS Educ, Title VIII, Art. 140 § 6951 provides the language for independent prescribing.

Rhode Island
216 RICR 040-05-23 provides a model of language that licenses midwives for independent practice with independent prescribing.

Model Language for Independent Midwifery Billing

Alaska
7 A.A.C. 145.100 provides model language for midwives to receive 100% the physician reimbursement from Medicaid.

Illinois
Ill. Admin Code tit. 89 § 140.400 provides model language for midwives to receive 100% the physician reimbursement from Medicaid.

Maine
CMR 10-144-101 provides model language for midwives to receive 100% the physician reimbursement from Medicaid.

Missouri
13 CSR 70-55.010 provides model language for midwives to receive 100% the physician reimbursement from Medicaid.

New Mexico
8.310.3.11 c(2) NMAC provides model language for midwives to receive 100% the physician reimbursement from Medicaid.

Ohio
Ohio Rev. Code Ann § 5160-4-04 provides model language for midwives to receive 100% the physician reimbursement from Medicaid.

Oregon
OAR 410-120-1340 provides model language for midwives to receive 100% the physician reimbursement from Medicaid.

Virginia
12 VAC 30-80-30 provides model language for midwives to receive 100% the physician reimbursement from Medicaid.

Washington
WAC 1820531-1900 provides model language for midwives to receive 100% the physician reimbursement from Medicaid.

Model Language for Independent Midwifery Hospital Admitting

Alaska
7 AAC 12.110 provides model language that allows hospitals to include midwives in medical staff and to admit independently.

Arizona
R9-10-207 provides model language that allows hospitals to include midwives in medical staff. R9-10-208 provides model language that allows midwives to admit independently.

Colorado
6 CCR 1011-1 ch 4 2.13 provides model language that allows midwives to join hospital medical staff.

Indiana
Burns Ind. Code Ann. § 16-21-2-5 provides model language that allows hospitals to include midwives in medical staff and to admit independently.

Iowa
51 IAC 481-51.1 provides model language that allows hospitals to include midwives in medical staff. 51 IAC 481-51.5provides model language that allows midwives to admit independently.

Nebraska
71-2048.01 provides model language that hospitals cannot deny medical staff or clinical privileges based on the individual's certification as a midwife.

Nevada
NRS 449.0302 provides model language that provides midwives the same signature authority for hospital admission as a physician.

Oklahoma
OK Reg. 310:667-7-6 provides model language that allows midwives to independently manage care in hospitals.

Oregon
Oregon ORS 441.064 provides a model of language that protects midwives' ability to be a full member of medical staff and to admit independently.

Wyoming
Wyo. Stat § 33-21-158 provides model language that gives midwives signature authority, allowing the midwife signature to serve anywhere a physician signature is required.

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