Report to the General Assembly

Midwifery Scope of Practice Review Committee Report
Pursuant to Public Act 22-58

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August 16, 2023

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Executive Summary

This report is submitted to the Connecticut General Assembly pursuant to Section 14 of Public Act 22-58, *An Act Concerning the Department of Public Health's Recommendations Regarding Various Revisions to the Public Health Statutes*. This section required the Department of Public Health (DPH) to convene a scope of practice review committee for midwives not otherwise currently licensed as nurse-midwives under Chapter 377 of the Connecticut General Statutes, and for such committee to consider whether DPH should regulate non-nurse midwifery.

During a series of six meetings, the Midwifery Scope of Practice Review Committee ("the Committee") considered a range of potential regulatory frameworks, studied cross-state comparisons of legislative and regulatory approaches to midwifery and out-of-hospital birth, and explored the historical, political, social, and cultural frameworks shaping community midwifery in Connecticut and nationwide. Topics of discussion included accountability mechanisms, transfer dynamics when homebirths require medical attention, medication administration, interprofessional challenges between midwives and other birthing care providers, the systemic racism at issue in both the maternal health care crisis and in the growth of demand for community midwifery, and the role of the state in addressing some of the barriers to the full scope of midwifery practice.

The Committee believes that in light of historic and present-day forces of systemic racism, and the systemic exclusion of midwives, Connecticut policy makers should proceed with great care and consideration. The Committee concludes that rather than adopting regulation or licensure immediately, DPH should continue to engage in careful discussions with the community of midwives and the families they serve to develop policy, foster public education, and seek understanding of ways to enhance choices in birthing care while ensuring the highest quality care is available to all Connecticut families.

Terminology

The following are defined to clarify their use in this report, and as used in the work of the midwifery Scope of Practice Review Committee. These are not legal definitions.

Certified midwife (CM)

- Midwife educated in midwifery according to American College of Nurse Midwives standards, who possesses a graduate degree in midwifery and passes a national certification examination administered by the American Midwifery Certification Board (AMCB) to receive the professional designation of CM. CMs may be trained to practice in home, community, hospital, or out-of-hospital settings.

Certified nurse-midwife (CNM)

- Midwife educated in both nursing and midwifery according to American College of Nurse Midwives standards, who possesses graduate degrees and passes a national certification examination administered by the American Midwifery Certification Board (AMCB) to receive the professional designation of CNM. CNMs may be trained to practice in home, community, hospital, or out-of-hospital settings. Connecticut requires CNMs to be licensed under Chapter 377 of the Connecticut General Statutes as ”licensed nurse-midwives" and prohibits any other person from assuming such title or using the abbreviation LNM or CNM (C.G.S. section 20-86e). In Connecticut a CNM successfully completes an accredited Registered Nurse program and passes the NCLEX RN exam including thirty hours of education in pharmacology for nurse midwifery.

Certified professional midwife (CPM)

- Midwife, trained in midwifery either through apprenticeship and/or through an accredited midwifery education program, and certified by the North American Registry of Midwives (NARM). The CPM credential is the only national midwifery credential requiring training and experience in community birth settings (planned home birth and freestanding birth centers).

Community midwife

- A midwife of any training or credential who practices in the out of hospital and community setting. Many midwives, including midwives of color, choose to practice as community midwives to reclaim traditional and community-based practices before, during, and after childbirth, and to indicate the emphasis on patient-centered and community-centered models of care as response to the maternal health disparities crisis and structural racism in the health care system.

Direct entry midwife or non-nurse midwife

- Any midwife trained without first training as a nurse. Many states regulate and license direct entry midwives, and many training and education programs are offered for direct entry pathways. These midwives are trained in out of hospital birth settings and may include CPMs, CMs, LMs, and community midwives.

Freestanding birth center

- A healthcare facility not attached to or located in a hospital, providing care for childbirth using the midwifery model. Connecticut law does not currently have a facility licensure category for birth centers, with the sole accredited freestanding birth center currently licensed as a maternity hospital under CGS 19a-505.

Home birth

- In this report, home birth refers to planned home birth, where a midwife assists and cares for the birthing person and infant during pregnancy, labor, delivery, and postpartum.

Home birth midwife

- A midwife of any background or credential who practices in the home setting and practices intrapartum care for planned home births.

International Confederation of Midwives

- A global non-governmental organization focused on supporting midwives' associations and promoting the profession of midwifery as the key autonomous care provider for birthing women.

Lay midwife

- Lay midwife may refer to an unlicensed or direct-entry midwife. Some midwives find this term outdated or derogatory.

Licensed midwife (LM)

- A category of professional licensure issued in some states, which may include both CPMs and other direct-entry midwives, including those trained and certified by the state's own apprenticeship and certification pathways as well as NARM certification.

Midwife

- A person trained to provide care and assistance to during pregnancy, childbirth and postpartum, as well as newborn care for the first six weeks of life, and well woman care throughout the lifespan. Includes midwives of any training or credentialing pathway, who practice the midwifery model of care in a range of settings.

Midwives model of care

- An approach to care based on the view that pregnancy and birth are normal physiological, social and community events. This approach incorporates a nurturing and hands-on model focused on developing a trusting relationship with clients, providing individualized support that includes physical, psychological and social well-being throughout the childbearing cycle, and refers women who require obstetrical attention. May be referred to as the midwifery model of care.[1]

Traditional midwife

- An unlicensed midwife practicing in their community and exempted from licensing requirements in some states. Traditional midwives in Connecticut may have formal or informal education from accredited or non-accredited midwifery education programs.

Transfer

- Transfer refers to the transfer of care from an out of hospital setting to a hospital, whether for emergent medical needs of birthing parent or infant, or due to non-emergent needs such as maternal exhaustion or maternal request for pain relief.

[1] The Midwives Model of Care is trademarked by the Midwives Alliance of North America, but the terms "midwives model of care" and "midwifery model of care" are also recognized and used globally without reference to this entity or trademark. Midwives Alliance of North America, *The Midwives Model of Care* Accessed January 5, 2022. https://mana.org/about-midwives/midwifery-model

Background

Throughout the conversations regarding potential regulation of midwifery, the Committee considered the racial, cultural, historical, social, and economic structures which have often excluded midwifery from mainstream maternity care systems. Midwifery as a profession predates modern obstetrics by millennia, and the professionalization of obstetrics historically entailed the displacement of midwives, and particularly midwives of color, from their roles as trusted community health providers.[2] The Committee reflected on how some midwives in the past century aligned with nursing to create the nurse-midwifery pathway to revive midwifery and expand access to midwifery care, yet the Committee agreed that midwifery and nursing are distinct and complementary health professions offering different models of care.

The Committee referenced the historical and ongoing harms on a national scale of laws and policies which have challenged the practice of midwifery despite the evidence base supporting improved health maternal and infant health outcomes for low-risk families receiving midwifery care, even as Connecticut state law has remained neutral on direct entry midwifery practice.[3] Reproductive justice requires an ongoing effort to address racism and racial bias in maternal healthcare in every aspect, in order to reach health equity.[4] The Committee acknowledges the impact of structural racism within medical and health establishments which continues a legacy of mistrust and shapes the racial disparities inherent to the current maternal health crisis. DPH highlights that Connecticut declared racism a public health crisis by statute in 2021, and as such the Committee strives to center health equity in its work and in this report as articulated under the DPH mission.[5]

Scope of Practice Review Process

The Scope of Practice Review Committee modeled its mandate after the provisions of sections 19a-16d to 19a-16f inclusive of the Connecticut General Statutes.[6] DPH has not previously conducted a scope of review for non-

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[2] Thompson, D. *Midwives and Pregnant Women of Color: Why We Need to Understand Intersectional Changes in Midwifery to Reclaim Home Birth*. Columbia Journal of Race and Law, 2016, *6*(1), 27–46. https://doi.org/10.7916/cjrl.v6i1.2312

[3] Harvard Law Review: Reproductive Justice. *The Legal Infrastructure of Childbirth, Ch. 3. Developments in the Law.* Vol. 134. No. 6, April 2021.

[4] Note that obstetrics as a profession is reflecting on the impact of racism in maternal health. *See* The American College of Obstetricians and Gynecologists. Racism in Obstetrics and Gynecology: Policy Statement. ACOG Board of Directors, approved February 2022. https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/racism-in-obstetrics-gynecology

[5] Conn. Gen. Stat. Sec. 19a-133. *See also*, Department of Public Health. *Health Equity Policies and Procedures.* HE-02-000, effective September 1, 2016. https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/hems/health_equity/HealthEquityPolicyandProceduresAugust2016pdf.pdf

[6] Any committee established pursuant to this section shall review and evaluate the scope of practice request, subsequent written responses to the request and any other information the committee deems relevant to the scope of practice request. Such review and evaluation shall include, but not be limited to, an assessment of any public health and safety risks that may be associated with the request, whether the request may enhance access to quality and affordable health care and whether the request enhances the ability of the profession to practice to the full extent of the profession's education

nurse midwives.[7] DPH posted notice of the review committee on its website and received statements of impact from representatives of the profession and other professions impacted. Each professional practice, association, or other entity submitting a statement of impact may provide up to two representatives to join the scope of practice review committee, and as such the committee was comprised of those individuals and organizations listed below from whom DPH received impact statements.

DPH received twenty-one statements of impact in response to the scope of practice working group notice posted on the DPH website. Of these, most statements were neutral with four expressing support for regulation and three expressing concerns about state regulation. Those in support articulated interest in integration and expansion of the midwifery model of care and expressed interest in improving transfers. Several statements voiced support for the licensure and regulation of certified midwives and drew links between access and choices in birth care and the improved recognition of midwives through regulation. Those statements expressing concern about regulation voiced lived experience that regulation had not solved the challenges of unequal dynamics between midwives and other healthcare professions, that regulation could curtail midwives' autonomy and scope of practice, and likewise that regulation may not improve transfer processes from the community to obstetric care. Three statements opposed regulation out of a concern that regulation would have the effect of reducing the number of community-based, homebirth midwives practicing, particularly those serving families of color, and could lead to more unassisted births or poorer access to traditional and culturally-sensitive birthing care.

The committee met virtually on a biweekly basis from October 19 to December 14, 2022, with an additional meeting on January 19, 2023. Meetings were facilitated by DPH staff.

This report is submitted in accordance with section 19a-16e(c) of the Connecticut General Statutes and includes in the list of resources all materials shared and considered by the Committee. Committee members had the opportunity to review and provide feedback on this report and the finding and recommendations therein. The Committee will be terminated upon submission of this report to the Public Health Committee of the General Assembly.

Scope of Practice Review Committee Membership

The Scope of Practice Review Committee was comprised predominantly of midwives currently practicing in Connecticut, and included certified professional midwives, a certified midwife, certified nurse midwives, and traditional midwives. Some nurse midwives joining the Committee work in hospital and clinical settings, but most are non-nurse midwives who provide care exclusively for planned homebirths. Of the twenty-seven committee members, seventeen are currently or formerly practicing homebirth midwives or current homebirth midwifery students, and amongst these are the only three currently practicing homebirth midwives of color in

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and training. The committee, when carrying out the duties prescribed in this section, may seek input on the scope of practice request from the Department of Public Health and such other entities as the committee determines necessary in order to provide its written findings as described in subsection (c) of this section. Sec. 19a-16e(b).

[7] Conn. Gen. Stat. § 19a-16d(b)(1)(G).

the state of Connecticut. The Committee also included advance practice registered nurses, and representatives of statewide and nationwide professional and credentialing organizations. The Committee noted the lack of any members of the general public to represent a full range of public views on birthing care in Connecticut; however, many Committee members shared positive midwife-attended birth experiences of their own including midwives, attorneys, and nurses amongst the group.

1. Allison Vail, RN, Connecticut Hospital Association
2. Amy Kohl, director of Advocacy and Government Affairs, American College of Nurse Midwives
3. Amy Romano, CNM, MBA, Founder and CEO of Primary Maternity Care
4. Angelica Tapia Ko, CPM, midwife
5. Camille Grant, midwife and owner of Rua Midwifery
6. Carolyn Greenfield, CPM and owner of Joyful Homebirth
7. Chris Andresen, MPH, Department of Public Health
8. Christina Mukon, DNP, CT APRN Society
9. Christy D'Acquila, CNM, CPM, and owner of Magnolia Midwifery
10. Dante Costa, JD, MPH, Department of Public Health
11. Dawn Havener, doula, CLC, student midwife, Empowered Beginnings Doulas
12. Elliann Slyvester, RN, Department of Public Health
13. Gengi Proteau, CPM and owner of Family Midwifery, President, CT Chapter of National Association of Certified Professional Midwives
14. Gwen Oppert, midwife and owner of Earth Dragon Babies
15. Ida Darragh, CPM/LM, Executive Director of the North American Registry of Midwives
16. Jody Mello, midwife and owner of Heart in Birth Midwifery
17. Kara Crawford, community midwife in private homebirth practice
18. Karen Buckley, Connecticut Hospital Association
19. Kimberly Sandor, MSN, RN, FNP, Executive Director CT Nurses Association
20. Lauriel Keys, doula and midwife at Primal Roots Midwifery
21. Lucinda Canty, CNM, PhD, Assistant Professor of Nursing, University of St. Joseph
22. Marian Seliquini, CM, MS, American College of Nurse Midwives Committee of Midwife Advocates for the Certified Midwife
23. Mary Lawlor, CPM and founder of the National Association of Certified Professional Midwives
24. Michelle Telfer, DNP, MPH, CNM, Assistant Professor & Co-Director, Midwifery Specialty, Yale School of Nursing
25. Priya Morganstern, attorney, former midwife
26. SciHonor Devotion, student midwife at Primal Roots Midwifery, doula and owner of Earth's Natural Touch: Birth Care & Beyond doula training and collaborative
27. Sera Gadbois, CPM, owner of Primal Roots Midwifery
28. Shana Jones, Department of Public Health
29. Stephanie Welsh, CNM, Mansfield Ob/Gyn Associates

Scope of Practice Review Committee Evaluation of Request

The following sections summarize the topics covered by the Committee members during their meetings. Elements of the Committee's discussion that are required for consideration within statutory scope of practice review processes under sections 19a-16d to 19a-16f inclusive of the Connecticut General Statutes are cited as

such in footnotes. All resources shared and discussed amongst the group are listed in the List of Resources at the end of this report, in accordance with Connecticut General Statutes Sec. 19a-16e(c).

1. Current Legal and Regulatory Status of Midwives[8]

Federal law does not govern the licensure or regulation of midwives.[9] However, recent federal policy initiatives speak to evidence of a growing consensus that midwives are a key component of strategies to improve maternal and infant health outcomes and systems in the United States. For instance, the White House Blueprint for Addressing the Maternal Health Crisis, issued June 2022, highlights the need for increased access to midwives under goal 4 (Expand and Diversify the Perinatal Workforce), including specifically increasing and expanding insurance reimbursement for midwifery care. Goal 4 also prioritizes expanding access to freestanding birth centers, commonly owned and staffed by midwives in states around the country, and demonstrating both improved outcomes for key maternal infant health indicators and lowered delivery costs.[10] Of note, peer nations with the best maternal and infant health outcomes also have a maternal health workforce dominated by midwives.[11] Just 10.3% of births in the US were attended by a midwife in 2020 (the most recent data available), making the US an outlier in contrast to most developed nations where midwives are integrated into primary care and maternity care systems.[12]

CNMs are governed by Chapter 377 of Connecticut General Statutes, which defines the scope of practice for nurse-midwifery.[13] Nurse-midwifery is defined in Connecticut statute as "the management of women's health care needs, focusing particularly on family planning and gynecological needs of women, pregnancy, childbirth, the postpartum period and the care of newborns, occurring within a health care team and in collaboration with qualified obstetrician-gynecologists" (Conn. Gen. Stat. § 20-86a). Midwifery as such, distinct from nurse-midwifery, is not covered by any provisions of Connecticut statute, and thus midwives who do not practice and qualify as licensed CNMs are unregulated in this state. Birthing outside of a hospital or institution is not

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[8] Conn. Gen. Stat. § 19a-16d(b)(1)(D).

[9] Jefferson, Karen et al. *The Regulation of Professional Midwifery in the United States*. Journal of Nursing Regulation. January 2021. Vol. 11, Issue 4. https://www.midwife.org/acnm/files/cclibraryfiles/filename/000000008271/Jefferson%202021%20Regulation%20Professional%20Midwifery.pdf

[10] According to data from the American Association of Birth Centers, which is the national accrediting agency for freestanding birth centers, 73% of birth centers nationwide are solely or jointly staffed by CPMs, and 58% are solely owned by CPMs. In terms of births attended at birth centers, only 2.7% are attended by physicians with the remainder attended by midwives. Unpublished AABC data analyzed and shared by Mary Lawlor, private communication, January 26 2023. MacDorman MF, Declercq E. Trends and state variations in out-of-hospital births in the United States, 2004-2017. Birth. 2019 Jun;46(2):279-288. doi: 10.1111/birt.12411. Epub 2018 Dec 10. PMID: 30537156. The White House Blueprint for Addressing the Maternal Health Crisis. June 2022. https://www.whitehouse.gov/wp-content/uploads/2022/06/Maternal-Health-Blueprint.pdf . For evidence on the impact of the midwifery model of care in birth centers as studied by the Center for Medicaid and Medicare Innovation, see Ian Hill et al. *Strong Start for Mothers Final Evaluation*, Volumes 1 & 2. 2018. https://innovation.cms.gov/innovation-models/strong-start

[11] Tikkannen, Roosa et al. *Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries*. Commonwealth Fund Issue Brief, Nov. 18 2020. http://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries#25

[12] American College of Nurse-Midwives. Fact Sheet: Essential Facts about Midwives. Updated April 2022. https://www.midwife.org/acnm/files/cclibraryfiles/filename/000000008273/EssentialFactsAboutMidwives_Final_2022.pdf

[13] Conn. Gen. Stat. Sec. 20-75 to Sec. 20-86 inclusive.

prohibited by law in Connecticut or in any state nationwide, and Connecticut regulations include birth certificate filing requirements for babies born out of hospital.[14] Some non-nurse midwives in Connecticut also practice in Rhode Island or Massachusetts. In Rhode Island, state law permits the licensing of CNMs, certified professional midwives (CPMs) and certified midwives (CMs) and prohibits the practice of midwifery without a license.[15] Massachusetts does not regulate non-nurse midwives, although efforts to pass legislation are ongoing.[16]

The practice of independent midwifery in Connecticut was considered in *Albini v. Conn. Med. Examining Bd.*, 72 A.3d 1208 (Conn. App. Ct. 2013), where the court held that the Connecticut Medical Examining Board (CMEB) did not have jurisdiction to determine that midwifery care of a normal pregnancy, birth and well-baby care constitutes the unlawful practice of medicine, based on the principle that pregnancy and childbirth are a "condition" rather than a pathology. The Court clarified CMEB authority to regulate the unauthorized practice of medicine, as limited to only those individuals who "diagnose, treat, operate for or prescribe for any injury, deformity, ailment or disease" without a license and not to those who care for the condition of normal pregnancy and childbirth. This decision leaves the determination of "normal" open to future interpretation and does not foreclose potential state regulation or prosecution of midwifery.

The Committee expressed a range of views about the legal status of midwifery practice and its impact on their autonomy and scope of practice, with some members satisfied with their ability to practice without regulation, and others concerned that midwives continue to risk criminal liability without administrative review as conducted by other health professions regulated by DPH. Committee members also discussed their concerns that when midwives provide medicines or conduct necessary procedures consistent with their training, such as responding to a postpartum hemorrhage, the language from the *Albini* ruling may place such midwifery care within the regulatory authority of DPH or the CMEB. In such instances, if the midwife intervenes appropriately, she may risk practicing outside her scope under current law, and this is a disincentive to providing appropriate care within midwifery scope and training.

2. Current education, training, examination and certification pathways in midwifery[17]

Midwives acquire their training and credentials via a variety of pathways in the United States, and states vary in how they license and regulate each pathway to midwifery practice. Three types of midwifery credentials in the United States meet the International Confederation of Midwives educational requirements, which set a globally accepted basis for midwifery training and competencies. Certified nurse-midwives (CNM) and certified midwives (CM) complete the same specialized midwifery training defined by the American Midwifery Certification Board, the distinction being that CNMs are trained as registered nurses (RNs) before or during their midwifery specialty training. Both CMs and Certified Professional Midwives (CPMs) are broadly defined as "direct entry" midwives, while CNMs are not direct entry midwives as their training includes a nursing degree.

The main categories of midwife with the associated credentials are as follows:

- Certified nurse-midwife (CNM)

[14] Conn. Regs. Sec. 19a-41-1 (1996).

[15] R.I. Gen Law § 23-13-9; for regulations see 216-RICR-40-05-23.

[16] In the 2022 Massachusetts legislative session, a midwifery licensure bill was sent to study. H. 4640 An act relative to out-of-hospital birth access and safety.

[17] Conn. Gen. Stat. § 19a-16d(b)(1)(F).

    - Minimum degree for certification: graduate degree
    - Minimum degree for entry to midwifery education program: bachelor's or higher from an accredited college or university
    - CNMs earn an advanced practice registered nursing degree prior to or during their midwifery education
    - Attainment of knowledge, skills, and professional behaviors as identified by the American College of Nurse-Midwives (ACNM) Core Competencies for Basic Midwifery Education Clinical education must occur under the supervision of an American Midwifery Certification Board (AMCB)-certified CNM/CM or other qualified preceptor who holds a graduate degree, has preparation for clinical teaching, and has clinical expertise and didactic knowledge commensurate with the content taught; >50% of clinical midwifery education must be under CNM/CM supervision. Note that the ACNM Core Competencies do require knowledge of planned out-of-hospital birth although most programs do not require direct clinical experience in such practice settings.
- Certified midwife (CM)
    - Minimum degree for certification: graduate degree
    - Minimum degree for entry to midwifery education program: bachelor's or higher from an accredited college or university
    - Attainment of knowledge, skills, and professional behaviors as identified by the American College of Nurse-Midwives (ACNM) Core Competencies for Basic Midwifery Education Clinical education must occur under the supervision of an American Midwifery Certification Board (AMCB)-certified CNM/CM or other qualified preceptor who holds a graduate degree, has preparation for clinical teaching, and has clinical expertise and didactic knowledge commensurate with the content taught; >50% of clinical education must be under CNM/CM supervision
- Certified professional midwife (CPM)
    - Minimum degree for certification: n/a, the CPM credential is based on meeting demonstrated competency and skills
    - Minimum degree for entry to midwifery education program: high school diploma or equivalent
    - The North American Registry of Midwives (NARM) defines the required competencies, which may be acquired either through a structured apprenticeship program or via a midwifery program or school. Graduates of Midwifery Education Accreditation Council (MEAC) accredited schools are qualified to take the NARM written exam. Both graduates of MEAC programs and those who complete the Portfolio Evaluation Process (PEP) are required to take the NARM exam to qualify as a CPM. NARM also accepts the completion of a Bridge Certificate, which includes a set of accredited continuing education units, as an equivalent qualification to MEAC education to sit for the NARM examination. The CPM credential emphasizes hands-on training in planned out-of-hospital birth settings.
- Traditional midwives
    - An unlicensed midwife practicing in their community and exempted from licensing requirements in some states. Traditional midwives in Connecticut may have formal or informal education from accredited or non-accredited midwifery education programs.
    - The term traditional midwife varies widely in state statutory definitions and global health usage.

3. Regional and national trends in midwifery licensing and scope of practice[18]

CNMs are licensed in all 50 states, though unlike Connecticut the majority of states license CNMs within nursing statutes as advanced practice nurses. Committee members discussed whether a separate category for nurse-midwives, as structured under Connecticut state law, is preferable to licensing CNMs under nursing laws as it delineates the distinct nature and autonomy of midwifery as a profession. A rapidly increasing number of states have legalized certified professional midwives (CPMs), and of the 37 states where CPMs may legally practice, 36 states regulate and license them.[19] The District of Columbia also regulates CPMs. Midwives and their supporters have lobbied for legislative changes to support their profession in the states that have adopted regulation, in order to practice to the full scope of their professional training.[20]

In New England, Maine (2016), Rhode Island (2014), Vermont (2000), and New Hampshire (1979) all regulate CPMs. Massachusetts has repeatedly considered legislation advancing and regulating non-nurse midwifery and out-of-hospital birth, including in the most recent session (2022).

In Maine, the statute governing complementary healthcare providers was amended to include midwives and require midwives to be licensed as of January 1, 2020. The law requires midwives, who are not nurse-midwives, to fulfill the requirements for either a certified midwife or certified professional midwife license. The licensing requirement expressly exempts traditional midwives, who only serve the communities of their cultural or religious group. The scope of practice for CPMs refers to the national standards issued by the National Association of Certified Professional Midwives, and includes ordering and interpreting laboratory tests and ultrasounds, as well as obtaining and administering medications within the scope of CPM education. The CPM scope of practice in Maine is limited to exclude schedule II, III and IV drugs, as well as prohibited cases with a "reasonable likelihood" of multiple gestation, breech presentation, vaginal birth after cesarean section, or conditions presenting moderate or high risk to parent or child. For CMs, the Maine scope of practice permits ordering and interpreting laboratory tests and ultrasounds, as well as obtaining and administering medications other than schedule II drugs.

In Rhode Island, the health department licenses both certified midwives and certified professional midwives. Rhode Island regulations define the practice of midwifery as authorizing licensees to:

> "practice the independent management of cases of childbirth, including prenatal, intrapartum, postpartum, and normal newborn care, and well woman care including the management of common health problems that provides for consultation, collaborative management, or referral as indicated by the health status of the client in accordance with standards established by the American College of Nurse-Midwives and Midwives Alliance of North America incorporated by reference."

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[18] Conn. Gen. Stat. § 19a-16d(b)(1)(J).

[19] The Big Push for Midwives. *Push States in Action*, map of state trends and chart tracking state licensure. Accessed January 10, 2023. https://www.bigpushformidwives.org/push_states_in_action

[20] Renee Cramer. *Birthing A Movement: Midwives, Law and the Politics of Reproductive Care*. Stanford University Press, 2021.

Rhode Island regulations list permitted medications under CM and CNM prescribing authority, as well as emergency medications permitted for CPMs who do not have prescribing authority, but may carry essential medications.

The Committee discussed aspects of the intent, structure, and impact of various states' regulatory approaches to midwifery. For a summary of points of comparison, see the Appendix to this report. Within these discussions, the Committee considered the challenges of providing for traditional midwives within regulatory structures, such that traditional midwives are not excluded from practice. A number of states have designed regulations with definitions of and exemptions for traditional midwives, including Maine and Oregon. In Maine, exemptions are limited to those midwives practicing specific cultural and religious birth practices within a specific community's tradition. In Oregon, traditional midwives are broadly defined and may practice without a license but are prohibited from medication administration and must provide the state Health Licensing Office Board of Direct Entry Midwives with a disclosure form for each client served.

Committee members voiced strong concerns that targeted restrictions of midwives' autonomous practice have proven difficult to avoid in the process of developing regulations in other states, and that before rushing to determine which regulatory structure might suit Connecticut, the Department and policymakers generally should develop thoughtful, equitable and trust-based processes to include midwives at every step. On the other hand, a few midwives on the Committee shared their own working experiences in other states which are both highly regulated and highly favorable to midwifery and out-of-hospital birth, including Texas and Washington state.

4. Potential Public Health and Safety Benefits and Harms of Regulation[21]

The occupation of midwifery plays a unique role in maternal and infant health, distinct from nursing, obstetrics, doulas, or other maternity care professions. Midwives are the only providers who focus on planned out-of-hospital birth in their training and education, and their evidence-based and globally recognized model of care meets the goals of the "Triple Aim" of healthcare improvement, namely improving the experience of care, improving the health of populations, and reducing per capita costs of health care.[22] The work of the Committee in reviewing midwifery scope of practice is undertaken with the public health goal of examining how to ensure the highest quality midwifery care is available to all mothers and birthing people and their families who wish to engage a midwife. Some members expressed how potential future regulation of midwives may also strengthen workforce development of a profession in great demand as more families seek community-based, culturally competent, and out-of-hospital options for birthing care. The Committee notes that meeting discussions on these topics were a very preliminary engagement with complex issues pertaining to the public health and safety implications of potential regulation, and much more discussion is warranted.

Midwives are the only professionals trained specifically in midwifery care, and thus trained to provide services to the full scope of midwifery practice; however, conducting this scope of practice review has allowed for preliminary consideration of the ways in which potential regulation might improve the integration of midwifery

[21] Conn. Gen. Stat. § 19a-16d(b)(1)(B).
[22] Berwick DM, Nolan TW, Whittington J. *The triple aim: care, health, and cost*. Health Aff (Millwood). 2008 May-Jun;27(3):759-69. doi: 10.1377/hlthaff.27.3.759.

into efforts to address the maternal health crisis. Evidence shows that integrating midwives into health care systems improves outcomes, and conversely that health outcomes suffer where midwives are poorly integrated with other maternity care providers and systems.[23] This scope of practice review was conducted with health equity at the forefront to better understand how midwifery regulation might improve or undermine health equity for underserved communities in Connecticut.[24]

The Committee reflected on how regulation, licensing, and integration of midwifery and out-of-hospital birth may and may not promote public health and health equity. Amongst the community midwives on the Committee, particularly the midwives of color, and amongst several of the other homebirth midwives, the choice to practice without securing the CPM credential despite sufficient training and experience to do so has been deliberate and conscientious. Concern about the racist history and current racial injustice observed in credentialing organizations, as well as a connection with birthing families who opt for homebirth services by community midwives precisely because they offer care outside of a maternity system perceived as harmful and unsafe to mothers and birthing people of color, has led to a movement away from both mainstream midwifery organizations and away from state regulation. The Committee heard expressions of concern that requiring a specific midwifery credential such as the CPM credential would exclude community midwives of color from their chosen practice.

5. Potential Impact of Regulation on Public Access to Health Care[25]

Homebirths are rising across the nation as well as in Connecticut, although absolute numbers of out-of-hospital births compared to hospital deliveries remain small. The most recent statistics available from the Centers for Disease Control show a 29% increase in births at home from 2019 to 2020 in Connecticut.[26] Part of the demand for out-of-hospital birth may be explained by concerns about COVID infection, or COVID-related restrictions imposed in labor and delivery units.[27] Increased demand for community-based maternity care options has also been noted in the context of racial and ethnic inequity in health outcomes for mothers, birthing people and infants.[28] Direct entry midwives currently serving Connecticut who joined the Committee confirmed that public demand for homebirth services is growing in their communities, even as pandemic restrictions on hospital birth have eased.

In addition to patient interest in community-based birthing options, Connecticut has faced a recent spate of proposed obstetrical service closures affecting community hospitals. Windham Hospital, Sharon Hospital, and

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[23] Vedam S, Stoll K, MacDorman M, Declercq E, Cramer R, et al. (2018) *Mapping integration of midwives across the United States: Impact on access, equity, and outcomes*. PLOS ONE 13(2): e0192523. https://doi.org/10.1371/journal.pone.0192523

[24] Eugene Declerq & Laurie Zephyrin. *Maternal Mortality in the United States: A Primer.* Commonwealth Fund Issue Brief & Report, Dec 16 2020. Maternal Mortality in the United States: A Primer | Commonwealth Fund

[25] Conn. Gen. Stat. § 19a-16d(b)(1)(C).

[26] Gregory ECW, Osterman MJK, Valenzuela CP. *Changes in home births by race and Hispanic origin and state of residence of mother: United States, 2018–2019 and 2019–2020*. National Vital Statistics Reports; vol 70 no 15. Hyattsville, MD: National Center for Health Statistics. 2021. DOI: https://dx.doi.org/10.15620/cdc:110853

[27] Aragao, Carolina. *Homebirths Rose 20% in 2020 as Pandemic Hit US.* Pew Research Center, July 28 2022. https://www.pewresearch.org/fact-tank/2022/07/28/home-births-rose-19-in-2020-as-pandemic-hit-the-u-s/

[28] Laurie Zephyrin et al. *Community-Based Models to Improve Maternal Health Outcomes*. Commonwealth Fund Issue Brief, March 4 2021. Community-Based Models Improve Maternal Outcomes and Equity | Commonwealth Fund; Harriet Jones. *Home Births Rise in Connecticut as Pandemic Prompts Women to Seek Alternatives to Hospitals*. Ct Mirror, Jan 2 2022. Home births rise in Connecticut as pandemic prompts women to seek alternatives to hospitals (ctmirror.org)

Johnson Memorial Hospital are all in the process of seeking Certificate of Need approval to close their labor and delivery services.[29] Hospitals face challenges related to financial resources, declining birth rates, and the ability to attract and retain staff. Connecticut Attorney General William Tong submitted comments to the Office of Healthcare Strategy regulating the proposed closures at Sharon, asking hospitals to balance these challenges against community need, and highlighting how the hospital's "proposal to close labor and delivery services risks exacerbating the very health disparities identified in the applicant's own [Community Health Needs Assessment]" of 2022.[30]

Exploring regulatory pathways for midwifery has the potential to serve public access to an expanded number of options for high quality birthing care, by meeting public demand for community-based birthing choices.[31] On the other hand, Committee members expressed fear that exclusionary or restrictive licensing laws risked forcing some community midwives to cease practice, thereby reducing access to options for the families they serve. This discussion centered on the role and scope of traditional midwives and warrants continued consideration of how states have worked to support access to traditional birthing practices.

6. Potential Impact of Regulation on Relationships with Other Healthcare Professions[32]

The Committee discussed challenges with current interprofessional dynamics as well as goals for transforming relationships with other healthcare professions involved in maternity care. These discussions were enriched by the presence of representatives of these professions and healthcare institutions on the Committee including CNMs, CMs, APRNs, birth center experts, and the state hospital association. Currently, non-nurse midwives practicing in the state of Connecticut are not consistently integrated with other providers in delivering maternity care, other than doulas for some midwifery practices, and they do not have formal collaboration agreements with other providers. Midwives noted that lack of collaboration is commonly linked to physician concerns including liability, and many midwives would like stronger working relationships with physicians because they and their patients must navigate these dynamics on a case-by-case basis. Direct-entry midwives do not practice in hospitals or have admitting privileges in any state, but they do own and staff freestanding birth centers in states around the country either independently or in collaboration with nurses, CNMs, or physicians.

Midwives on the Committee detailed a range of both positive and negative experiences with physicians, hospital systems, and other providers when transferring from the home setting. Nurse midwives on the Committee working within hospital systems expressed an interest in improving transfer protocols to provide better support

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[29] For documentation of ongoing certificate of need proceedings before the Connecticut Office of Health Strategy regarding labor and delivery closures, refer to the OHS website. https://portal.ct.gov/OHS/Pages/Certificate-of-Need/Public-Hearings. Katy Govala. *Battle over Windham Hospital birthing unit enters final stages*. CT Mirror, Aug 31, 2022. https://ctmirror.org/2022/08/31/windham-hospital-birthing-unit-hartford-reproductive-health/ ; Patrick Sullivan. *Area officials speak out against obstetrics plan*. Lakeville Journal, Oct 20 2021. https://tricornernews.com/lakeville-journal-regional/sharon-hospital-area-officials-speak-out-against-obstetrics-plan

[30] Attorney General William Tong. Re: Comments concerning Certificate of Need Application: Docket Number: 22-32511-CON Termination of Labor and Delivery Services at Sharon Hospital. Letter of Dec, 6, 2022. https://portal.ct.gov/-/media/AG/Press_Releases/2022/12-06-22-William-Tong---Comments-on-Sharon-Hospital-CON-FINAL.pdf

[31] Jane Sandall et al. *Midwife-led Continuity Models Versus Other Models of Care for Childbearing Women.* Cochrane Review. April 28, 2016. https://doi.org/10.1002/14651858.CD004667.pub5

[32] Conn. Gen. Stat. § 19a-16d(b)(1)(H), Conn. Gen. Stat. § 19a-16d(b)(1)(K).

for community home birth midwives. For instance, one major hospital system in the state has a policy requiring referral of all homebirth transfers to maternal-fetal medicine specialists, despite the data that over 95% of transfers out of the home or community setting to obstetric care are non-emergent.[33] The Committee discussed how hospital midwives can be ideal transfer partners for community midwives, and the Committee would like to strengthen these relationships and protocols to improve continuity of care and improve hospital understanding of the midwifery model of care in the full range of birth settings, while acknowledging the hospital association's concerns regarding the complex issues pertaining to liability and regulation inherent to transfers and transfer agreements

The Committee's discussions on interprofessional dynamics and challenges also raised issues related to:

- Transfer and transport to hospital setting, and reliance on emergency response personnel who lack training or awareness of home birth
- Lack of continuity of care in case of transfer, lack of consultation and collaborative care
- Issues with practice or collaboration agreements
- Eligibility for reimbursement both from Medicaid and from private payers, as well as parity of reimbursement between midwives and other providers for the same health care services
- Prescribing authority, if any – lack thereof
- Ability to own and practice in freestanding birth centers, which are not currently a licensed facility category under Connecticut law

An underlying tension in this area of discussion arose repeatedly in the Committee's work, namely the challenge of wanting to elevate and mainstream midwives for a more seamless transfer experience with better outcomes on the one hand, while ensuring that midwives maintain their independent ability to practice to the full scope of their training in accordance with the midwifery model of care.

7. Potential Economic Impact of Regulation on the Healthcare Delivery System[34]

The Committee shared a range of views on the potential economic impact of regulation on active midwifery practices in Connecticut. Substantial research supports the high-value nature of midwifery care, including significant economic savings achieved by lower interventions including a lower c-section rate and lower postnatal complication and infant hospitalization rate as compared to low-risk deliveries in hospitals.[35]

Midwives expressed interest in the possibility of owning and staffing birth centers in the future to expand the scope and setting of their care, but many expressed doubts that reimbursement rates would be structured in an equitable manner. Historically, midwives nationwide, including CNMs practicing in the hospital setting, have been denied payment parity, meaning the same rates for the same healthcare services received by other

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[33] Blix, E., Kumle, M., Kjærgaard, H. *et al. Transfer to hospital in planned home births: a systematic review*. BMC Pregnancy Childbirth 14, 179 (2014). https://doi.org/10.1186/1471-2393-14-179

[34] Conn. Gen. Stat. § 19a-16d(b)(1)(I).

[35] Attanasio, LB et al. *Midwife-led care and obstetrician-led care for low-risk pregnancies: A cost comparison*. Birth: Issues in Perinatal Care. 2020 Vol. 47, p57– 66. https://doi.org/10.1111/birt.12464

providers, by either public or private payers. In Connecticut, CNMs achieved payment parity in Medicaid reimbursement in 2021. Evidence demonstrates that inequitable reimbursement for midwifery services denies Medicaid recipients access to midwifery-led care, including birth center care.[36] Concerns with Medicaid reimbursement included not just parity with other providers, but concerns that reimbursement rates for maternity services broadly were too low to sustain midwifery care to the full extent of its scope in providing individualized care. [37]

Homebirth midwifery practices in Connecticut currently rely on a combination of patients' out of pocket payment, patients who secure insurance reimbursement on their own for their care, and community support to allow families who would not otherwise be able to afford a homebirth to receive midwifery care. In other states with licensure and regulation, CPMs and other licensed midwives are generally eligible for Medicaid reimbursement, though CPMs generally remain out-of-network for private insurance and coverage for their services varies.[38] The economic burden of criminal liability, which despite the *Albini* ruling remains a possibility for Connecticut midwives, was also discussed by the Committee. Committee members put forth related arguments in favor of administrative review structures and for professional malpractice insurance coverage which could become available with regulation.

Midwives on the Committee who practice traditionally and without a CPM credential expressed that state regulation without a provision for traditional midwifery would risk the closure of their practices, and thus the economic consequences of potential regulation could be absolute. Thus, although evidence suggests transitioning more birth care to a midwifery model may create cost savings and improve outcomes at the system level, individual midwives have serious concerns about the economic impact of regulation on their ability to provide services.

8. Potential Impact of Regulation on the Midwifery Profession's Ability to Practice to the Full Extent of the Profession's Education and Training[39]

The Committee found common ground in the notion that the alignment, in relatively recent history, of midwifery with nursing was an uneasy fit – combining midwifery with nursing was a strategy to bring midwives back to mothers and birthing people, but the group discussed how separating midwifery from nursing under state law could work to elevate midwifery as a profession in its own right. The midwives on the Committee, regardless of their training, education or pathway to the profession, agreed that their commitment to and employment of the midwifery model of care in whatever setting they may practice was the most fundamental aspect of their work and a choice that unites midwives broadly.

Midwives on the Committee also broadly agreed on the importance of professional autonomy and rejected models of regulation requiring physician oversight. The Committee discussed whether and how regulation and

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[36] Courtot, Brigette et al. *Midwifery and Birth Centers Under State Medicaid Programs: Current Limits to Beneficiary Access to a High-Value Model of Care*. The Milbank Quarterly, 98, p1091-1113. https://doi.org/10.1111/1468-0009.12473

[37] Attanasio, LB et al. *Midwife-led care and obstetrician-led care for low-risk pregnancies: A cost comparison*. Birth: Issues in Perinatal Care. 2020 Vol. 47, p57– 66. https://doi.org/10.1111/birt.12464

[38] National Academy for State Health Policy. *Midwife Medicaid Reimbursement Policies by State*. State Tracker and Map, updated April 15, 2022. https://nashp.org/midwife-medicaid-reimbursement-policies-by-state/

[39] Conn. Gen. Stat. § 19a-16d(b)(1)(L).

licensure might expand the practice setting or flexibility of practice for midwives. They expressed interest in the role of direct-entry midwives in both owning and staffing freestanding birth centers should such facilities be established in the state. Both the direct entry midwives and the nurse-midwives on the Committee agreed that direct-entry midwives should be closely involved in establishing, owning and, staffing birth centers in the future; however, as raised by the state hospital association, the establishment of freestanding birth centers poses complex threshold issues such as licensing requirements and agency regulatory oversight.

Several voices on the group articulated an interest in at least limited regulation to facilitate legal access to medication, ultrasounds, and testing in line with other states' legislative trends. The Committee discussed whether skills that overlap with other healthcare professions, such as suturing or administering medications, should be subject to regulation. Others voiced interest in the potential to expand the midwifery workforce in Connecticut to meet demand for community birthing care, including supporting the training of new generations of students. Committee members also voiced strong interest in leadership development and business support for opening birth centers and other community-based childbirth care practices.

The Committee discussed administrative review and accountability models and mechanisms over the course of multiple meetings. Midwives disagreed on whether the current peer review model of accountability in their professional community is sufficient. The Committee heard an overview of how professional accountability and peer review are structured within the licensed and certified professions at the Department, and the Committee learned about midwife-led models of emergency drills to improve coordination and response in transfers.

Overall, the Committee heard significant concern that despite intentions to elevate and expand midwifery, any potential regulation risked interference and control from maternity care providers, healthcare facilities and institutions who are not educated in planned out-of-hospital birth or dedicated to the midwifery model of care. Members of the Committee questioned whether, given the history of laws and policies that single midwifery out for inequitable restrictions, any regulation could avoid ultimately curtailing both access for many families, and restricting the full scope of practice of community midwives as they currently serve Connecticut families. These concerns were expressed within the framework of seeking racial equity in health outcomes, linking the individualized and culturally competent nature of community midwifery care to improved outcomes for families of color.

Scope of Practice Committee Findings and Recommendations

The Committee's work revealed profound differences in views on the impact of potential regulation, but also threads of profound common ground. The Committee recognized the unique opportunity in Connecticut to consider midwifery and community birth in a cohesive and thoughtful manner, because non-nurse midwives have not been historically regulated as they have been in other states. The Committee expressed a desire to draw on midwifery in a broader effort to make Connecticut a leader in reforming maternal health and addressing inequitable outcomes.

The Committee finds that:

1. Policymakers, consumers, and healthcare providers should understand the legacy of the regulation and restriction of midwifery, and such understanding must include the ways that racism continues to present barriers both external to the profession, and within the profession of midwifery itself.

2. Committee members share a commitment to the midwifery model of care in all birth settings and recognize the value midwifery care brings not just in economic terms but in responding to the structural factors shaping the current national crisis in maternal health disparities. The Committee shares an understanding that midwifery care is not medicine or nursing and should be recognized and respected as an independent profession.

3. Regulation and licensure are not sufficient on their own to achieve the reforms to the birthing care system the Committee discussed, nor can regulation alone improve birthing care or resolve challenging dynamics between midwifery and other health professions.

4. The Committee articulated a vision of successful engagement with state government that would include:
    a. Improving access to midwifery care and increasing recognition of the midwifery model of care
    b. Transforming birthing care practices across birth settings to be more individualized and culturally competent, thereby addressing root factors leading to racial disparities in maternal and infant health outcomes
    c. Uplifting midwives and including them in the implementation of any policy implicating their work
    d. Listening to midwives of all pathways already practicing in their communities across Connecticut.

Given these findings, the Committee recommends the following:

1. Any continued discussion of midwifery regulation and licensure must be made carefully and with recognition of racism past and present in state law, in professional organizations, and in the healthcare system.

2. The Committee recommends the General Assembly approve the formation of a working group to continue discussion on regulation, public health and safety and improving birthing care in all settings, including but not limited to topics such as the licensure of Certified Midwives in Connecticut, designing and implementing education strategies to improve public awareness of birthing options, education for emergency medical services personnel to improve transfer experiences and outcomes, and strengthening options for community birth to address growing maternity deserts and racial disparities in outcomes in Connecticut. The Committee recommends representatives of families to join such discussions to ensure inclusion of their perspectives.

3. The Committee recommends the General Assembly and Committee of Cognizance include direct entry midwives as experts and leaders in out-of-hospital birth as they consider the licensure and establishment of freestanding birth centers.

4. The Committee recommends all future policy engagement on midwifery consider the scope of midwifery practice as extends to the full reproductive life course, as well as reflecting an understanding of the maternal-infant dyad as a unit requiring integrated care within the midwifery model of care.

Appendix: Selected Comparisons of State Regulation of Midwifery

Definition	Unified definition of "**licensed midwifery**" • Washington (in statute) • Rhode Island (in regs)	Distinct categories of midwife in statute • Maine (CPM and CM)	
Licensing	Single midwifery license • New Jersey • New York (CM and CNM only)	Distinct license categories (note many states license CNMs as APRNs, some license CMs as LMs) • Eg ME and RI where CMs are licensed separately from both CPMs and CNMs	
Scope	Defining scope of practice in **regulation** • Rhode Island (at 23.9)	Defining scope of practice in **statute** • Maine (separate provisions for CPMs and CMs under the same statute) • California	
Relationship with other providers	Required physician **collaboration** • New Jersey • California • Note a few states still require physician supervision of CNMS • Note also collaboration requirements are often one-sided, meaning physicians are not statutorily required to enter	Duty or responsibility to **consult** • Illinois – note Illinois (and New Hampshire) allows a CNM to be the consulting professional • Washington in statute, must be submitted in writing to health dept	

	them and leaving midwives unable to secure such agreements.	• Vermont (midwife maintains involvement) • Massachusetts (proposed but failed in 2022)	
Transfers	Regulating transfer **protocols** • California (all transfers reported to state)	Mandated transfer **agreements** • New Jersey (within physician collaboration agreement) • Vermont	**Flexible** on transfers • Texas
Boards	**Unified** Board of Midwifery • Eg Rhode Island "Advisory Council on Midwifery"	**Separate** Boards of Midwifery • Eg Alaska Board of Certified Direct Entry Midwives	Oversight by **Medical** Board • California • New Jersey (has Midwife Liaison Committee)
Credentials	Adopting **national** credentials • Idaho (CPM – NARM certification)	Administering **own certification** process (including state exam) • New Mexico (at 16.11.3.12)	Going **beyond** national credentials • Oregon **(**in regs)
Practice Standards	Adopting **national** standards • Oregon, New Jersey - MANA	**Guidelines** for midwives to set their own protocols • New Mexico	

Exemption for traditional midwives	• Oregon (at 687.415) - note each client served requires a disclosure form to be filed. • Maine • Illinois (sec. 25 exemptions) • (note Minnesota statute covers licensed midwives/CPMs as "traditional midwives")
Licensing CMs	• See chart for current states licensing CMs with and without restriction
Formulary privileges	• Rhode Island • Idaho (includes specific protocols)
Medicaid reimbursement for licensed midwives	• Oregon
"grandmothering" clause	• New Hampshire (at section D:14)
Reporting requirements	• New Mexico – does not follow MANA reporting • Idaho – incorporates reporting into peer review requirements • Rhode Island • Vermont (every 2 years)

List of Resources

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