Lay midwives and the ObGyn: Is collaboration risky?

ObGyns have a long history of collaboration with their nurse-midwife colleagues—possibly one of the strongest collaborative traditions in medicine. But when lay midwives enter the picture, does collaboration become a risky proposition for you?

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"We have indeed in America medical practitioners not inferior to the best elsewhere; but there is probably no other country in the world in which there is so great a distance and so fatal a difference between the best, the average, and the worst."

—Flexner report from 1910[1]

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ObGyn is a risky specialty, with no guarantee of a perfect outcome, even with the best education, training, and skills. Does collaboration make it riskier? Or can collaboration help you deliver high-quality care to your patients?

This article explores these questions as they relate to provision of health care in collaboration with midwives—specifically, certified nurse midwives (CNMs), who are approved by the American Midwifery Certification Board, and certified professional midwives (CPMs), who are not. (See the box on page 22 for a more detailed discussion of different types of midwives in practice today.)

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ILLUSTRATION: MARY ELLEN NIATAS FOR OBG MANAGEMENT

Who's who in the midwifery world

Got acronym fatigue? Here's a rundown of the various credentials and certifying organizations.

The American College of Nurse-Midwives (ACNM) is a professional organization established in 1955 for certified nurse midwives and certified midwives. ACNM sets standards for academic preparation and clinical practice. For more information, visit http://www.midwife.org.

The American Midwifery Certification Board (AMCB) is the certification organization affiliated with ACNM. This board was formerly called the ACNM Certification Council (ACC). Certification by AMCB is equivalent to certification by ACC.

In 1997, AMCB opened its national certification exam to nonnurse graduates of midwifery education programs and issued the first certified midwife credential. Since 2010, a graduate degree has been required for entry into clinical practice for both certified nurse midwives and certified midwives. http://www.amcbmidwife.org

Certified midwife (CM). In 1996, the ACNM adopted standards for the certification of direct-entry midwives. These midwives undergo the same certification process as certified nurse midwives, but their training does not include education in nursing. CMs must pass the same certification exam as CNMs and must have a master's degree.

CMs are licensed in only three states: New Jersey, New York, and Rhode Island. New York had the first CM training program and was the first state to recognize the CM credential. It is the only state that has one unified framework for licensing all midwives—both CNMs and CMs.

Certified nurse midwife (CNM). A midwife who has training in both nursing and midwifery. A master's degree is required for certification. These midwives typically have prescriptive authority for most drugs; are eligible for third-party reimbursement, including Medicaid; and practice independently or in collaborative practice with physicians.

Certified professional midwife (CPM). In the mid 1990s, the CPM credential was developed jointly by the Midwives Alliance of North America (MANA), the North American Registry of Midwives (NARM), and the Midwifery Education Accreditation Council (MEAC). There is no single standard for education; both apprentice-only–trained midwives and midwives who undergo university-affiliated training use the title CPM.

A CPM can learn through a structured program, through apprenticeship, or through self-study. Another route to the credential is current legal recognition to practice in the United Kingdom. CPMs must pass a written and practical exam for certification.

According to MANA, 24 states recognize the CPM credential as the basis for licensure or use the NARM written exam. Some of these states use a different nomenclature. For example, licensed midwife (LM) is used in California, Idaho, Oregon, and Washington; licensed direct-entry midwife (LDM) is used in Utah; and registered midwife (RM) is used in Colorado.

SOURCE: ACOG[10]

Moving away from a physician-oriented system

Like it or not, change is under way. Subtle but important shifts are taking place in the way maternity care is provided in your community.

The challenges facing our specialty? Ensuring that the highest levels of patient safety and quality care are maintained. And educating federal and state lawmakers, insurers, and the public accordingly.

Free-standing birth centers are gaining prominence

The Patient Protection and Affordable Care Act (ACA) establishes alternative pathways for maternity care. Congress, state lawmakers, and insurers want to know: Can access to quality maternity care be provided at lower cost outside of hospitals or by nonphysicians? The answer isn't clear.

Under the ACA, free-standing birth centers are a Medicaid maternity-care choice for low-income women. Birth centers appeal to lawmakers and insurers because of their lower cost. For example, in 2008, the average facility cost for a vaginal delivery in a hospital, with no complications and no newborn charges, was $8,920. In 2010, the average facility cost for a similar delivery at a birth center was $2,277.[2,3]

We know that dollars alone don't tell the full story—but they're easy listening to lawmakers' ears.

Since 2010, Medicaid payments are allowed to go to state-licensed, free-standing birth centers even if they are not operated by or under the supervision of a physician. Before the ACA became law, Medicaid paid only for services provided in ambulatory centers under the supervision or oversight of a physician.

Another important change: Medicaid now reimburses for the services of any provider who practices in a state-licensed, free-standing birth center as long as that provider is practicing within the state's scope of practice laws and regulations. That means that if a state allows doulas or lay midwives to provide childbirth care in free-standing

birth centers, the federal and state Medicaid programs will pay for this care. This policy is consistent with "any willing provider" rules found elsewhere in Medicaid.

There are 215 birth centers in the United States, with more in development. The number of birth centers has increased more than 20% over the past 5 years; they are regulated in 41 states.[4]

ACOG's Guidelines for Perinatal Care asserts: "The hospital, including a birthing center within a hospital complex, or freestanding birthing centers that meet the standards of the Accreditation Association of Birth Centers, provide the safest setting for labor, delivery, and the postpartum period."[5]

Reimbursements for nonphysicians are increasing

Beginning in 2011, the Medicare program began reimbursing CNMs, the most highly trained midwives, at 100% of the physician payment rate for obstetric services. Until 2011, CNMs were paid at 65% of the physician's rate for the same billed services.

In addition, from 2011 through 2015, CNMs whose primary care services account for at least 60% of their Medicare-allowed charges will receive Medicare bonus payments of 10%, reflecting Congress' concern that our nation faces a serious shortage of primary care providers.

Another important provision goes into effect in 2014: All health plans offered in a state insurance exchange must accept and pay any provider recognized under state law for services covered by that plan. CPMs, some of whom are among the least highly trained providers, are licensed to provide maternity care in 24 states. This provision may put pressure on health insurers to pay for maternity care provided by CPMs, regardless of their training and certification, even if the insurer doesn't contract with these providers.

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In 2011, Medicare began reimbursing CNMs, the most highly trained midwives, at 100% of the physician payment rate for obstetric services

"Even a normal pregnancy can become high-risk"

In 2008, the Massachusetts legislature debated expanding childbirth care to encompass less highly trained providers. ACOG President Kenneth L. Noller, MD, MS, cautioned them about the move, saying: "Even a normal pregnancy can become high-risk with little or no warning, and serious, sometimes life-threatening complications may arise for the woman and her fetus."

He noted that shoulder dystocia occurs in one in every 200 births and listed the frequency of other complications:

- prolapsed umbilical cord: 1 in every 200 births
- life-threatening maternal hemorrhage: 1 in 250
- eclamptic seizures: 1 in 500
- uterine inversion: 1 in 700
- Apgar score of 0–3 at 5 minutes: 1 in 100 to 200.

Three years later, ACOG President Richard A. Waldman, MD, and American College of Nurse Midwives (ACNM) President Holly Powell Kennedy, CNM, PhD, wrote: "Collaborative practice [is] the provision of health care by an interdisciplinary team of professionals who collaborate to accomplish a common goal, and is associated with increased efficiency, improved clinical outcomes, and enhanced provider satisfaction."[5]

These messages demonstrate the importance of *careful use* of collaboration to manage risk and maintain the highest standards of patient care. The questions for ObGyns who are considering collaborative practice:

- What is careful use?
- How do you collaborate carefully, without increasing the risks faced by your patients and your practice?
- How do you make collaboration a success?

ACOG has taken on these questions and offers sound practical advice.

ACOG recommends high standards and clear practice agreements

ObGyns have a long history of collaboration with our nurse-midwife colleagues—possibly one of the strongest collaborative traditions in medicine. ACOG supports the practice and licensure of trained midwives

credentialed by the ACNM. CNMs are well-educated, highly trained, and well-integrated into the health-care system.

In addition to the ACNM standards, ACOG supports the "global standards for midwifery education" established by the International Confederation of Midwives (ICM) in 2010:

- The minimum entry level of students is completion of secondary education
- The minimum length of a direct-entry midwifery education program is 3 years
- The minimum length of a post-nursing/health-care provider program is 18 months
- Standards are congruent with current core ICM documents and position statements.

ACOG strongly encourages that in no case should the professional standards of any maternity provider be less than the standards established or accepted by ACOG or the ACNM.

Effective collaboration depends on clear practice agreements between physicians and CNMs, consistent use of shared practice guidelines, and malpractice insurance coverage of all parties. A collaborative agreement that clearly spells out the mechanism for consultation, collaboration, and referral is essential to assure the best care.

The picture gets a little trickier—and riskier—when we look at less-trained maternity providers.

A majority of CPMs lack adequate training

Few of the nation's 1,400 CPMs in practice today meet the educational and training standards accepted by ACOG and the ACNM. The educational background of CPMs—known in some states as direct entry or lay midwives—varies widely across the nation. Unlike CNMs, CPMs are not required to have a nursing background. They practice primarily in out-of-hospital settings, including birthing centers and private homes. Many CPMs have no formal academic education or medical training, and their training requirements fall short of internationally established standards for midwives and traditional birth attendants.

Other relevant points:

- A person without a high school degree could be licensed as a CPM if he or she passed the certifying exam, observed 20 deliveries, and participated as the primary attendant in 10
- As a group, CPMs have not adopted home-birth patient-selection criteria that are based on generally accepted medical evidence or public safety
- The curriculum, clinical skills training, and experience of CPMs have not been approved by the American Midwifery Certification Board. Nor are they reviewed by the American Board of Obstetrics and Gynecology or the American Board of Family

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Medicine—recognized authorities in the certification of knowledge and skills associated with the practice of obstetrics.

- The North American Registry of Midwives' Portfolio Evaluation Process requires midwives to be the primary care provider during 50 home births and to have 3 years' experience. The average ObGyn resident gets this much experience in 1 month.

CPMs who lack a high school diploma and are apprentice-trained only (without core curriculum training and formal academic experience) clearly do not meet ACOG standards. Therefore, ACOG cautions its Fellows and the public that, for quality and safety reasons, it "does not support the provision of care by ... midwives who are not certified by the American Midwifery Certification Board" [ACNM's accreditation body]. Certification by this board, then, is a good indication of skill.

Requirements for successful collaborative practice

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Successful collaboration between ObGyns and certified nurse midwives can improve job satisfaction and health outcomes

Where can you look for examples of collaboration that work, and for data on the effects of collaboration on health-care outcomes? Four articles in the September 2011 issue of *Obstetrics and Gynecology* highlight successful models of collaboration between ObGyns and CNMs in very different, well-established maternity programs.[6-9] In each article, the authors describe their collaborative practice model in some detail, offering guidance to others interested in successful collaboration. Common threads run through these narratives:

- trust
- communication
- mutual respect
- administrative support for continuing medical education
- consensus meetings
- common adherence to accepted guidelines
- an established support network for back-up and transfer.

The benefits to ObGyns include greater job satisfaction. Benefits to patients include improved health outcomes, as demonstrated, for example, in a model from Washington State: a high rate of vaginal delivery, low rate of cesarean birth, high rate of successful vaginal birth after cesarean (VBAC), and low rate of repeat cesarean delivery.[7]

ACOG's policy on collaborative practice finds its origins just over 100 years ago in the Flexner report, quoted at the beginning of this article, which emphasized the need to ensure that medical care in the United States is of no less quality than in other parts of the world.[1]

Medical education and quality of care have improved dramatically over the past century. ACOG is working to ensure the highest standards of care for pregnant women, standards no lower than for the rest of the population.

Collaboration is a time-honored tradition in ObGyn. Doing it right is key to patient safety.

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