Appendix 1: Midwifery Practice Settings

Note that this overview focuses primarily on Certified Nurse-Midwives (CNMs) in the State of California.

Setting	Description	Advantages	Disadvantages	Implementation Strategies
Hospital-Based	The CNM is employed or contracted by a hospital and provides deliveries and outpatient services in facilities. Also note that, • Number of FTEs varies with volume • Midwives may provide antenatal and intrapartum care • Consultation can be provided by existing physicians	• Folded into an existing infrastructure • Having midwives may present the hospital with a competitive advantage • Midwives can bill for services provided • Minimal or no additional liability insurance cost • May be able to draw upon grant funds • Hospital receives inpatient facility fee from any new business	• Cost of salary and benefits may be greater than revenue during start-up period • Increased overhead by the addition of outpatient clinic space, support staff, etc. • Depending on hospital capacity, additional volume may require additional inpatient space and staff	• Identify hospitals in underserved areas who might consider integrating midwives into their setting and initiate conversations with the leadership team • Continue the dialogue with community physicians to identify potential consultants for midwives • Explore community partnerships for referrals with health departments, Planned Parenthood, pregnancy support centers • Develop a business plan or concept paper that addresses key variables and projections • Consider integrating other “value-added” services from midwives, such as C-section first assist
Community-Based	The CNM is employed or contracted by the department of public health or a community health center, such as a federally qualified health center (FQHC) or rural health center (RHC). Also note that, • Sites may offer prenatal and/or	• Folded into an existing infrastructure • Streamlined collaboration with other support services, such as behavioral health • Organization has familiarity with the needs of patient population	• Primary care providers may lack familiarity with midwifery model • Recruitment of midwives to more rural areas can be difficult • Provider compensation in public health settings is often lower than in a private organization	• Initiate dialogue with community physicians to identify potential consultants for midwives • Identify outpatient clinic space • Explore existing funding sources for potential expansion dollars • Develop a business plan or concept paper that addresses key variables and projections

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	intrapartum care only and refer to a hospital • The organization may have an existing relationship with physicians to provide consultation services • The community hospital may already provide support to a health department or clinic	• Increases access to care in the community • Generally, no increase in liability insurance • Outpatient visits may be reimbursed at a level higher than in a private setting (as per FQHC criteria)		
Physician-Owned Practice	The CNM is employed or contracted by a medical group, independent physician association (IPA) or solo practice.	• Folded into an existing infrastructure • Physicians may view the addition of midwives as an asset, providing their practice with a competitive advantage and workload relief • A practice considering recruiting an additional physician may prefer to add midwives who typically have lower compensation than physicians • Midwives can refer complicated OB and GYN cases to physicians, increasing revenue generating potential	• To offer continuity of care with midwives, more than one midwife is needed to launch practice • Cost of salary and benefits may be greater than revenue during start-up period • Increased overhead by the addition of outpatient clinic space, support staff, etc. • Cost of liability insurance for midwives may be greater than for a hospital-or community-based practice • Recruitment to rural areas may be difficult	• Initiate dialogue with community hospitals to explore delivery capacity and potential for shared financial risk • Explore community partnerships for referrals with health departments, Planned Parenthood, pregnancy support centers • Develop a business plan or concept paper that addresses key variables and projections

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Midwifery Private Practice	The CNM owns and operates the practice and can contract with physicians for consultation.	• Independent practice allows development of a small start-up model with minimal overhead • Working with a midwife already practicing in the community could build upon existing relationships with patients, referral sources, physician consultants, and hospitals • A small start-up practice may be eligible for loans or other support from the small business association	• Challenges partnering with hospitals that do not currently credential midwives • Overhead costs, including liability insurance may be high • Recruitment to rural areas may be difficult	• Identify midwives within targeted areas who may be interested in starting a private practice that offers hospital deliveries • Continue the dialogue with community hospitals to explore delivery capacity and potential for shared financial risk • Explore community partnerships for referrals with health departments, Planned Parenthood, pregnancy support centers • Develop a business plan or concept paper that addresses key variables and projections
Faculty Practice	The CNM is employed or contracted by an academic medical center (a school of nursing or school of medicine). In these settings, the CNM may allocate more time to clinical training of residents or CNMs in training than in other practice settings. Faculty of existing midwifery education	• Many midwifery programs are searching for faculty practice options as a source of revenue and clinical education sites for students • Local midwives may collaborate with the midwifery programs to serve as clinical faculty	• Midwifery programs can struggle to find qualified faculty; it may be challenging to find and fund additional FTEs for faculty practice sites • Universities may not have the financing for a start-up site	• Identify directors or other key decision makers of midwifery education programs in your state and programs that offer distance learning with clinical experiences in your community • Schedule an initial discussion with interested parties to explore the possibility of faculty practice expansion to the target area • Broaden the discussion to potential hospital partners and physician

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	programs can expand to provide care in the defined areas.			consultants in the community to assess interest in midwifery • Develop a business plan or concept paper that addresses key variables and projections
HMO-Based	Midwives are employed by a HMO or integrated care organization.	• Existing infrastructure and, often, resources to support midwifery patients (i.e., multispecialty referral base, social workers, educators) • If OB/GYN physicians are employed by the HMO, they can serve as consultants to the midwives	• Many HMOs focus on the bottom line and can be slow to add new services • Physicians employed by or contracted with an HMO may perceive midwifery as a competitive threat	• If HMO has a clinical practice base, explore the possibility of adding midwifery services • Develop a business plan or concept paper that addresses key variables and projections