Certified Nurse Midwifery Training in Maine: A Feasibility Study

An RMOMS GRANT

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Maine Hospital Association

EXECUTIVE SUMMARY

The Maine Hospital Association (MHA), funded by the **Rural Maternity & Obstetrics Management Strategies (RMOMS)** grant, conducted a feasibility study to evaluate the establishment of a **Certified Nurse Midwife (CNM) training program in Maine**. The study aimed to address workforce shortages, improve maternal health access in rural areas, and explore sustainable training models.

This assessment was developed with support from the MaineHealth Rural Maternity and Obstetrics Management Strategies (RMOMS) grant number UK9RH46984, through the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS). The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by HRSA, HHS or the U.S. Government.

Purpose & Rationale

- Maine faces **growing maternal health workforce challenges**, particularly in rural communities.
- CNMs provide comprehensive reproductive and maternity care, improving outcomes and reducing intervention rates.
- Expanding CNM training could strengthen maternal health, reduce disparities, and improve retention.

Key Findings

Current Workforce:

- 44 CNMs practicing statewide; median of 3 per hospital.
- 78% of hospitals allow CNMs full scope of practice; some require physician co-signature.

Training Capacity:

- 5 hospitals currently train CNM students; 6 more expressed willingness if barriers (low patient volume, preceptor shortages, policy hurdles) are addressed.

Barriers:

- No in-state CNM academic program; reliance on out-of-state programs.
- Limited preceptor capacity and lack of compensation.
- Geographic and logistical challenges for rural placements.

Program Design Options

New Maine-based CNM Program:

- Determined **not feasible** due to high cost, accreditation complexity, and limited student pool.

Strategic Partnerships:

- Collaborate with existing programs (Yale, Georgetown, Frontier Nursing University) for clinical placements in Maine.

Post-Graduate Pathways:

- **Transition-to-Practice (TTP):** 6-12 months structured onboarding with mentorship and simulation.
- **Fellowship Model:** 12-24 months formal program with competency-based curriculum, simulation, and rotations across rural sites.
- Both models aim to improve confidence, retention, and readiness for rural practice.

Infrastructure & Support

- Utilize **Building ME Network** and **Clinician Nexus** for placement coordination and microgrants for housing, travel, and technology.
- Preceptor support is critical: stipends ($1,000-$2,000 per rotation), protected time, and professional development.

Cost & Funding

- **TTP Model:** Moderate cost; requires salary support during reduced clinical workload and structured education.
- **Fellowship Model:** Estimated $130,000-$185,000 per fellow annually (salary, benefits, faculty time, simulation, admin).
- **Funding sources:** CMS reimbursement (30-60% for accredited programs), state/federal workforce grants, philanthropic support, microgrants.

Recommendations

1. Align hospital policies to ensure CNMs practice at full scope statewide.
2. Launch public awareness campaign to elevate CNM role and career pathways.
3. Formalize clinical training pathways via affiliation agreements with out-of-state programs.
4. Secure funding for preceptors and student supports (housing, stipends).
5. Integrate standardized simulation and didactics across Maine.
6. Develop **Maine-based Fellowship or TTP model** for new CNM graduates.
7. Leverage statewide platforms (Clinician Nexus) and microgrant programs for rural placements.

Conclusion

Maine has strong interest and foundational capacity to expand CNM training through **strategic partnerships and structured post-graduate programs** rather than creating a new academic program. Implementing fellowship or TTP models, combined with policy alignment and preceptor support, will strengthen the midwifery workforce, improve maternal health outcomes, and ensure sustainability.

PROJECT OVERVIEW

The Maine Hospital Association, through funding from the Rural Maternity & Obstetrics Management Strategies (RMOMS) grant, conducted a feasibility study to evaluate the establishment of a Certified Nurse Midwife (CNM) training program in Maine.

The overarching goals of this study are to assess the demand and feasibility for such training, identify key academic and clinical partners, and explore models that may include either a standalone institutional program or a consortium-based approach. The study also aims to directly address workforce shortages in rural and underserved communities, with a particular focus on enhancing access to maternal healthcare services.

SCOPE OF CNM PRACTICE

Midwifery in Maine is supported by a clear regulatory framework that distinguishes between Certified Nurse Midwives (CNMs) and Certified Professional Midwives (CPMs). CNMs are graduate-level practitioners who have completed programs accredited by the Accreditation Commission for Midwifery Education (ACME) and hold national certification through the American Midwifery Certification Board (AMCB). In Maine, they are licensed as advanced practice registered nurses (APRNs) and practice with full prescriptive authority. CPMs, meanwhile, are licensed under Maine law (Title 32, Chapter 113-B). Their scope of practice includes ordering and interpreting laboratory tests, conducting ultrasounds, administering certain medications (apart from Schedule II-IV controlled substances), and providing maternity, newborn, and reproductive health care.

The scope of midwifery practice in Maine is broad and encompasses the full reproductive health continuum. Midwives provide preconception and family planning services, including counseling, contraceptive care, and health screenings. They manage prenatal care, offering comprehensive monitoring throughout pregnancy, education, and the management of low-risk complications. Midwives also attend births, supporting women through normal labor and delivery across a range of settings that include hospitals, birth centers, and home environments within the bounds of regulation.

Care does not end at birth, as midwives provide extensive postpartum follow-up, including maternal recovery, lactation support, and newborn assessments. For newborns, midwives typically provide well-baby care during the first six to eight weeks of life. CNMs also provide broader women's health and primary care services, extending their role beyond maternity into ongoing gynecological and reproductive health. In fact, the World Health Organization (WHO) contends that midwives could be providing 90% of sexual and reproductive care in the United States but the predominant structure of the healthcare system does not support this care model. [1]

SCOPE OF CNM PRACTICE

The benefits of midwifery care are well established in the research literature and align closely with Maine's maternal health needs. Midwifery-led care is associated with lower intervention rates, including fewer caesarean sections, inductions, epidurals, and assisted vaginal deliveries. Outcomes are consistently positive, with evidence of lower rates of preterm birth and stillbirth, reduced maternal complications, and higher breastfeeding initiation.

The continuity in midwifery models–where women are cared for by the same provider or small team throughout pregnancy, birth, and postpartum–leads to stronger relationships, greater trust, and more positive birth experiences. These models are also cost-effective, reducing reliance on high-cost interventions and shortening hospital stays.

In the context of Maine, midwifery's holistic and relationship-based model is particularly well suited to addressing workforce shortages and the unique challenges of rural healthcare delivery. Maine is fortunate to have a strong CNM workforce and while midwives are known for attending births, 55.1% of Maine CNMs identify reproductive care and 38.5% identify primary care as responsibilities in their full time positions, demonstrating their scope of practice and impact on communities.[2] By expanding access to midwifery services, Maine has an opportunity to strengthen maternal health outcomes, improve patient satisfaction, and create a more sustainable, community-based model of care.

[1]American College of Nurse-Midwives: ACNM Workforce Study, Executive Summary. 2022
Midwifery Workforce Study - American College of Nurse Midwives
[2]Ibid.

CONVENING A BROAD STAKEHOLDER GROUP & MEETING SUMMARIES

The MHA convened a group of stakeholders which included, but was not limited to, practicing nurse midwives, nurse midwife faculty, health systems, educational institutions, and state partners, including the Maine Department of Health and Human Services and Department of MaineCare. The first meeting, held on July 30, 2025, established the foundation for discussions around CNM training. Maine is seen as progressive in its approach to midwifery, with nearly one-fifth of births attended by midwives compared to only ten percent nationally. Yet, significant workforce challenges exist.

Participants identified both opportunities and challenges. Fellowship models, such as the one at Mass General Brigham, were highlighted as a possible model to emulate, and potential funding sources were discussed through the Transforming Maternal Health (TMaH) initiative and upcoming rural infrastructure programs. Partnerships with institutions like Frontier Nursing University and Boston College were seen as feasible avenues for accelerating training pathways. However, barriers remain, particularly the limited availability of clinical placements driven in part by the limited capacity of preceptors, organizational resistance in some hospitals, and the absence of patient preference data to guide planning. The meeting concluded with a commitment to explore fellowship feasibility, survey hospitals to assess demand and capacity, expand the stakeholder group, and pursue collaborations with existing programs.

CONVENING A BROAD STAKEHOLDER GROUP & MEETING SUMMARIES

The second meeting, held on September 5, 2025, built on the earlier discussion and incorporated results from a statewide survey of hospitals. The hospital survey found that Maine has forty-four CNMs in practice, with a median of three per hospital. Five hospitals currently train CNM students, while six expressed willingness but noted barriers such as low patient volumes, heavy CNM workloads, and the lack of formal affiliation agreements. Despite these challenges, there was evidence of strong potential for expanding training capacity. Most hospitals reported that their CNMs practice at full scope, although one hospital still requires physician co-signature.

Opportunities identified included regional student rotations, the use of the Building ME Network and Clinician Nexus platform for placement and preceptor support, and the development of fellowship or transition-to-practice programs. Public awareness campaigns and physician champions were also seen as critical for normalizing and advancing CNM integration across Maine. Action steps included drafting affiliation agreements, exploring funding and preceptor support mechanisms, and designing fellowship models tailored to the state's needs.

The third and final meeting for the study was held on October 3, 2025, and delved into some of the earlier identified strategies for expanding CNM training in Maine, including clinical placement pathways, advanced training or fellowship models, and broader policy and cultural changes needed to support midwifery workforce. Participants emphasized the importance of creating consistent clinical placement systems by supporting preceptors through compensation and protected time and leveraging existing statewide infrastructure such as the Clinician Nexus platform and Building ME Network microgrants. A major theme centered on the feasibility of developing formal post-graduate pathways, specifically "transition-to-practice" and fellowship models, to provide structured mentorship and competency-based learning for new CNMs. These models were seen as vital for bridging the gap between education and practice, reducing burnout, and improving retention, particularly in rural settings. Broader conversation also touched on aligning midwifery training with workforce policy initiatives, integrating simulation and community-based models of care, and ensuring equitable access to maternal health services across Maine's regions.

MAINE HOSPITAL SURVEY FINDINGS

The statewide hospital survey was sent to 14 rural and urban birthing hospitals and had 11 responses or a 79% response rate (Appendix A). The responses from the eleven hospitals revealed that nine hospitals employ CNMs while two do not. In total, forty-four CNMs are practicing, with most hospitals employing only a small number, although some larger institutions report as many as ten. Training capacity is mixed: five hospitals already accept CNM students, generally on a small scale, while six others are open to doing so if barriers such as patient volumes, preceptor availability, and policy constraints are addressed. Nearly all respondents indicated a willingness to expand training if the necessary supports are in place.

In terms of practice, seventy-eight percent of hospitals allow CNMs to function at full scope, including prescribing, billing, and recognition as medical staff, while a small minority impose restrictions requiring physician co-signatures. Workforce demand was uneven, with most hospitals not actively recruiting, though at least one site reported an immediate need for three CNMs and another anticipated the need for one to two additional providers. Respondents agreed that rural hospitals represent the greatest growth opportunity for midwifery expansion. The survey participants pointed to several potential strategies to expand midwifery workforce, including the development of a statewide training program with regional rotations, shared precepting models, policy standardization to ensure consistency of practice, and targeted recruitment initiatives aimed at rural communities.

CNM CLINICAL TRAINING REQUIREMENTS & CLINICAL PLACEMENT CONSIDERATIONS

Early discussions with stakeholders, including written communications with Maine-based academic institutions, made it clear that establishing a new Certified Nurse Midwifery (CNM) training program in Maine would be highly challenging and likely not the best use of the state's limited resources. Institutions cited several barriers, such as the significant time and cost required to build the necessary infrastructure, difficulty securing qualified faculty, the lengthy and expensive accreditation process, and the high ongoing operational costs relative to the small pool of prospective students.

Several institutions noted that similar efforts had been explored in the past and were deemed not feasible in the foreseeable future. As a result, conversations quickly shifted toward identifying existing CNM programs outside of Maine, understanding their clinical training requirements, and exploring strategic partnerships that could bring CNM trainees to Maine for clinical education and potential future employment.

Discussions with academic partners highlighted the clinical training requirements necessary for Certified Nurse Midwife (CNM) students, which need to be considered to expand clinical placements in Maine. At Yale University, students must meet the American Midwifery Certification Board (AMCB) requirements to be eligible for the boards. This involves a traditional midwifery integration model that requires students to complete approximately forty clinical hours per week. These hours typically combine inpatient and outpatient midwifery care, though the exact schedule may be adapted to fit the norms of the practice. For example, some students may work two twelve-hour inpatient shifts and two eight-hour outpatient shifts per week, while others may adjust to twenty-four hour call schedules or longer office shifts. Throughout their training, students are evaluated by their preceptors, and a declaration of clinical safety must be signed at the end of each semester to confirm readiness.

CNM CLINICAL TRAINING REQUIREMENTS & CLINICAL PLACEMENT CONSIDERATIONS

Frontier Nursing University offers another pathway that is popular among labor and delivery nurses in Maine, as it allows students to remain in their home environment while completing their education due to it being an online training program with only two in-person training weeks per year. Several Maine practicing CNMs noted that they have taken students from the Frontier University program for clinical rotations demonstrating an established connection between this program and Maine's healthcare organizations. In this program, students are responsible for arranging their own clinical placements (Frontier Nurse Midwifery Program). Georgetown University, which is a new program, also has an online nurse midwifery program that can be completed in as few as 23 months (Georgetown University Nurse Midwifery Online Program). One benefit to an online program is that there may be a way to partner with these programs more directly to support a pathway for Maine applicants into these programs and create satellite locations for hands on training as needed.

Clinical placements in CNM programs are competency-based. Students are required to achieve both skill mastery and a specific number of clinical procedures before graduation. For instance, most programs require students to attend around forty births. These arrangements generally do not create direct costs for hospitals, though loss of productivity and burden on the clinical preceptor must be considered. Many organizations see the benefit of hosting students as a form of extended interview for potential future hires. Although most schools do not pay organizations to take students, exceptions exist. For example, the Massachusetts General Institute of Health Professions provides $2,000 to individual preceptors for a four-week outpatient placement in its physician assistant program, a practice more common in medical education than in nursing. And, the Yale CNM program provides compensation to preceptors, offering $1,500 for a full-year placement or $1,000 for integration-only placements. Preceptors also receive courtesy faculty benefits. Additional resources for Yale's preceptor support and orientation are available online (Yale Nursing Preceptor Resources).

CNM CLINICAL TRAINING REQUIREMENTS & CLINICAL PLACEMENT CONSIDERATIONS

Clinical Placements

The successful expansion of Certified Nurse Midwife (CNM) education in Maine depends on strengthening the clinical training infrastructure that connects learners, educators, and practice sites. Two statewide initiatives, Building ME and Clinician Nexus, provide foundational tools to coordinate placements and expand access to rural training opportunities.

The Building ME Network was created to expand and strengthen rural clinical education opportunities across Maine. Originally funded through the Maine Department of Health and Human Services and federal public health grants, the initiative aims to increase the number and diversity of health profession students training in rural areas. The program awards microgrants of up to $15,000 to remove barriers that prevent healthcare organizations from hosting learners. Funds can be used flexibly for practical needs such as housing for students, travel reimbursement, educational technology, and small infrastructure improvements to accommodate trainees.

Program administrators noted that, contrary to initial expectations, most requests did not focus on preceptor compensation. Instead, hospitals and clinics prioritized overcoming logistical barriers that made rural placements difficult demonstrating that expanding training capacity requires addressing foundational access issues, such as transportation, lodging, and technology, before preceptorships can thrive.

Building ME provides a strong foundation for increasing CNM placements in rural communities, particularly if future funding can be targeted toward maternal and reproductive health disciplines. Continued investment in this program could help create a more equitable distribution of clinical learning opportunities across the state and serve as a scalable model for other advanced practice disciplines.

CNM CLINICAL TRAINING REQUIREMENTS & CLINICAL PLACEMENT CONSIDERATIONS

The Clinician Nexus platform represents a statewide effort to modernize and centralize the clinical placement process. Adopted by multiple hospital systems and supported by the Maine Hospital Association, the platform enables healthcare organizations and academic institutions to coordinate student placements through a shared online system.

Clinician Nexus includes a "marketplace" feature that allows clinical sites to post available placement opportunities by discipline, schedule, and required competencies. Academic programs can then search and apply for these opportunities on behalf of their students. The system also allows hospitals to track learners, monitor placement capacity, and evaluate long-term recruitment potential by maintaining visibility into where students train and whether they later join the Maine workforce.

Stakeholders highlighted this initiative as particularly relevant for midwifery, given that Maine has no in-state CNM program and relies heavily on partnerships with out-of-state universities. The platform's statewide reach can bridge that gap, providing a transparent and efficient mechanism to match CNM students with Maine-based preceptors and facilities. Additionally, the ability to gather aggregate data on placements and workforce outcomes can inform policy and planning efforts related to maternal health and rural workforce distribution.

Challenges for CNM Preceptorship and Education

Despite these established initiatives, Maine's ability to expand CNM training remains constrained by workforce pressures and systemic barriers faced by practicing midwives. Midwifery is unique among advanced practice disciplines in that it lacks a formal academic presence in the state. There are no Maine-based CNM programs and therefore no faculty appointments or funded teaching roles dedicated to midwifery education.

CNM CLINICAL TRAINING REQUIREMENTS & CLINICAL PLACEMENT CONSIDERATIONS

As a result, clinical precepting often relies on voluntary contributions from midwives already managing heavy clinical and on-call workloads. Participants in meetings reported that midwives across Maine face increasing patient volume, staffing shortages, and limited administrative support, all of which contribute to burnout. The additional responsibilities of mentoring and evaluating students without compensation or protected time have become unsustainable for many.

Several midwives in the discussion emphasized that meaningful progress requires recognition of preceptorship as an educational function by providing stipends for teaching time, administrative or clinical release time to accommodate learners and provide effective feedback, professional development opportunities to become better teachers, and ensuring midwives have representation and compensated administrative time in statewide planning and workforce development efforts.

There has been growing discussion about compensation models for CNM preceptors in Maine. Historically, small hourly stipends have been used, such as $15 per hour for nurse practitioners or physician assistant students. However, many now consider lump-sum payments to be more practical and easier to manage. Suggestions include payments in the range of $1,000 to $2,000 for an eight-week placement. Other incentive models could involve non-monetary rewards such as additional vacation days, or institutional-level incentives managed through hospitals rather than individual preceptors. In practice, students are often shared between two midwives or across a group practice, as is the case at Brigham and Women's Hospital and Wentworth Hospital. Overall, while the prevailing model remains unpaid, the discussion reflects increasing awareness of the burden on preceptors and the need to support them in training future midwives.

Without these supports, participants cautioned that even with improved placement infrastructure through initiatives like Building ME Network and Clinician Nexus, the system may continue to rely on overextended clinicians, limiting growth and sustainability.

CNM FELLOWSHIP OR "TRANSITION TO PRACTICE" MODEL

As part of the broader assessment of Certified Nurse Midwife (CNM) training feasibility in Maine, the working group examined structured post-graduate training models that could strengthen workforce readiness, retention, and rural placement. The discussion centered on two complementary models: the Transition-to-Practice (TTP) approach and the Formal Fellowship Model, both designed to bridge the gap between academic education and independent clinical practice.

Newly graduated CNMs often experience significant challenges transitioning into full practice, particularly in rural and resource-limited settings. These challenges include limited mentorship, lack of exposure to rare but critical obstetric emergencies, and variability in onboarding processes across institutions. Without structured support, early-career CNMs may experience professional isolation or leave the state for better-supported positions elsewhere.

Structured post-graduate training programs whether in the form of a transition-to-practice track or a formal fellowship provide a defined framework to support competency development, professional confidence, and workforce sustainability. Such models have demonstrated success in related advanced practice disciplines, such as physician assistant and nurse practitioner programs, and could be adapted to the midwifery context in Maine.

Transition-to-Practice Model

The Transition-to-Practice (TTP) model offers an extended onboarding experience, typically lasting six to twelve months. This model is appropriate for newly hired CNMs who are fully credentialed but require structured mentorship and education to consolidate skills. Typically, in this model, CNMs are hired full time but initially spend only 60-75% of their time in clinical practice ramping over several months to a year. The remaining time is used to gain additional exposure in other clinical settings, for instance rotating through different hospitals or clinics, conduct simulations and participate in didactics and mentorship.

CNM FELLOWSHIP OR "TRANSITION TO PRACTICE" MODEL

This model works due to the structured mentorship the participants receive from experienced CNMs and Obstetricians with immediate feedback on their skill acquisition combined with protected learning time and professional development with the end goal of independent practice. This approach enables new CNMs to practice under guidance while maintaining full employment status and salary. It serves as an effective middle ground for organizations unable to fund a full fellowship but still seeking to ensure quality, safety, and workforce retention.

Fellowship Model

The Fellowship Model represents a more formalized, competency-based post-graduate training structure, typically lasting 12 to 24 months. Fellows are employed as learners within a defined program, often at a reduced salary, and receive comprehensive clinical, didactic, and professional development support.

The fellowship model is defined by a curriculum that outlines core competencies which are met through structured clinical rotations, simulation-based training, and didactic modules covering obstetric emergencies, gynecologic care, pharmacology, and interprofessional collaboration. It includes formal competency assessments aligned with established standards, all supported through faculty oversight provided by a program director, associate director, simulation lead, and program coordinator. Emphasizing interdisciplinary education, the model promotes collaboration across healthcare disciplines to ensure fully integrated maternal and newborn care. Stakeholders noted that it's critical for any advanced practice provider fellowship program to be successful, it must have physician support and ideally a physician champion. Fellows learn within a protected environment where they serve as employed learners with a clearly defined scope of practice and strong support systems, distinct from independent staffing responsibilities.

CNM FELLOWSHIP OR "TRANSITION TO PRACTICE" MODEL

Nationally, similar programs for Advanced Practice Providers have shown high retention rates–up to 75%–and improved confidence and clinical performance. Applying this model to CNM education would create a formal pathway for clinical excellence and workforce stabilization. A resource for future work in this area is the is the Consortium for Advanced Practice Providers which has been a national leader in the Nurse Practitioner and Physician Assistant fellowship movement.

Program Design Considerations for Maine

Regardless of whether Maine moves forward with a TTP model or a more formal structure like a Fellowship, stakeholders agreed that a hub-and-spoke structure was the most feasible for Maine's geographic and institutional landscape. Under this proposed design, a centralized hub at a larger birthing facility would provide core didactics, simulation-based education, and statewide coordination as a central entity. In many cases, didactics and simulation-based education could be accomplished inter-professionally combined with physician and nurse training. The regional spokes would allow fellows to rotate among multiple rural sites, gaining experience across a variety of environments and communities. These rural rotations would be critical to ensuring CNMs are well equipped for independent practice in rural settings where there are fewer clinical and material resources. A key piece to the hub and spoke model would be the shared faculty and infrastructure, which increases the sustainability of a program over time. The common curriculum and evaluation tools also maintain standardization regardless of where a fellow is training while at the same time leveraging the expertise of local providers.

CNM FELLOWSHIP OR "TRANSITION TO PRACTICE" MODEL

To ensure viability and success, the proposed program must incorporate several components. First, it should establish clearly defined competency frameworks specifically tailored to midwifery practice, emphasizing both emergency obstetric care and the complex decision-making required in rural clinical environments. These competencies would serve as the foundation for structured learning and consistent assessment across training sites. Second, the program should integrate simulation-based education to prepare fellows for rare but high-stakes clinical situations that may not occur frequently in routine practice. Simulation offers a safe and controlled environment for developing technical proficiency and clinical judgment. Third, the program must include robust evaluation and feedback mechanisms to track fellow progression, identify learning needs, and ensure competency attainment throughout the training period. Finally, successful implementation will depend on well-supported preceptors, as noted above. This includes providing preceptor development opportunities, dedicated administrative time for teaching responsibilities, and appropriate compensation to recognize the critical role these clinicians play in mentoring the next generation of certified nurse midwives.

COST CONSIDERATIONS

The level of investment needed to expand Certified Nurse Midwife (CNM) training in Maine will vary depending on the approach the state chooses. If Maine strengthens partnerships with out-of-state CNM programs and uses existing tools such as Clinician Nexus to coordinate clinical placements, costs will remain relatively modest. In this scenario, the primary expenses involve supporting students during their clinical rotations. These may include housing assistance, preceptor development, and stipends for preceptors who supervise learners. Some programs offer stipends between $1,000 and $2,000 per rotation, though this is not consistent across institutions.

A Transition-to-Practice (TTP) model or a formal fellowship requires a more substantial and ongoing investment. In a TTP model, a new CNM typically practices at 0.6 to 0.75 FTE during the first six to twelve months, gradually increasing their clinical workload. During this time, the CNM receives mentorship, structured education, and access to additional clinical settings. Because the organization pays a full-time salary while the new provider works a reduced clinical schedule, revenue generation is temporarily limited. Additional costs include didactic activities, case review sessions, simulation training, and the dedicated time that experienced clinicians spend on oversight, feedback, and evaluation.

A fellowship model represents the most significant investment in infrastructure. Insights from a comparable Critical Care Advanced Practice Provider (APP) Fellowship pro forma provided by Maine Health help illustrate the typical cost structure for advanced practice training. These costs include salary, benefits, faculty and preceptor time, administrative support, simulation and didactic resources, and malpractice coverage. Using that model as a guide, the financial framework for a CNM fellowship can be outlined to help stakeholders understand both the initial investment and the long-term potential benefits, including improved workforce stability, reduced recruitment expenses, and strengthened clinical capacity across the state.

COST CONSIDERATIONS

Fellowship costs fall into two broad categories: direct trainee expenses and the infrastructure required to sustain program operations. Fellows are usually paid a reduced but competitive salary. Drawing from APP fellowship salaries in Maine, a CNM fellow would likely earn between $65,000 and $75,000 annually, with benefits adding roughly $16,000 to $22,000. Professional liability coverage adds an additional $700 to $1,000 each year. Fellows also require structured didactic learning and simulation-based training to build competency in obstetric and gynecologic care. These learning activities are estimated to cost between $5,000 and $10,000 per year, with another $2,000 for conferences and continuing education.

Faculty and preceptor time is often the largest programmatic expense. Comparable fellowship models suggest that 0.25 to 0.40 FTE of combined clinician effort is needed per fellow, at an estimated annual cost of $30,000 to $50,000. This includes program leadership, curriculum oversight, individualized learning plans, and precepting across multiple clinical sites. Administrative support adds further cost, typically between $15,000 and $25,000 per fellow each year, to manage scheduling, onboarding, affiliation agreements, learner tracking, and accreditation-related functions. Additional operational needs–such as educational technology, learner management systems, evaluation tools, and basic program supplies–are estimated to cost $3,000 to $5,000 annually.

Altogether, the expected annual cost of supporting one CNM fellow is estimated between $130,000 and $185,000, depending on program design, salary assumptions, cohort size, and institutional efficiencies.
Although fellowships do not function primarily as revenue-generating programs, they do provide meaningful value that offsets some expenses. As fellows progress through their training year, they gradually increase their clinical work, and the latter half of the program often includes measurable billable activity. Based on the APP model, a CNM fellow may generate $50,000 to $80,000 in revenue during the fellowship. Beyond this, retention is one of the strongest long-term benefits. APP fellowship programs often retain 70 to 80 percent of graduates, reducing the need for costly recruitment and helping organizations build a more stable workforce. If designed with accreditation in mind, a CNM fellowship may also qualify for partial reimbursement from CMS or other federal programs, which can cover 30 to 60 percent of allowable program costs.

FUNDING AND SUSTAINABILITY

Initial implementation would require combined funding sources, including philanthropic support, state and federal workforce grants, and institutional investment. Long-term sustainability could be achieved through partial federal reimbursement (CMS) for accredited fellowship programs via established cost-reporting mechanisms. Integration with state workforce initiatives, such as the Rural Health Transformation Program, which prioritizes workforce innovation and rural clinician support could provide initial funding to develop and implement infrastructure until federal funding through CMS, which typically taking up to three years, would be available. Lastly, microgrants and foundation funding through Consortium for Healthcare Education and Training (CHET), for example, should be leveraged to support preceptor training, learner housing, and travel between sites.

Estimated costs should include program administration, faculty time, learner stipends, and operational expenses for didactic and simulation components.

Both the Fellowship and Transition-to-Practice models provide critical mechanisms to strengthen the midwifery workforce pipeline in Maine. The TTP approach offers an achievable short-term solution for organizations seeking to improve onboarding and retention, while the fellowship model presents a long-term investment in advanced, structured clinical training.

CONCLUSIONS & RECOMMENDATIONS

The feasibility study to date indicates both a strong interest and several barriers to creating a CNM training pipeline in Maine. While not all hospitals are currently seeking to hire CNMs, upcoming retirements and uneven workforce distribution, especially in rural areas, highlight future demand and the importance of planning for the future. While some infrastructure already exists, with five hospitals actively training CNM students, expansion will require formalized agreements, additional preceptor support, and greater policy alignment. Strategic opportunities include the development of fellowship or TTP programs, regional clinical rotations, and collaborations with out-of-state academic partners. Standardizing CNM scope of practice across institutions and increasing public awareness about the role and value CNMs play in their communities will also be key to strengthening the midwifery workforce.

CONCLUSIONS & RECOMMENDATIONS

Recommended next steps:

1. Align hospital policies across to reflect the full scope of Certified Nurse Midwifery in Maine, ensuring that all CNMs work in their full scope of practice as allowed in Maine.
2. Launch a communications campaign to elevate the visibility of the care CNMs provide to patients and communities, and the attractiveness of CNM careers. What is a Midwife? Midwife Resources.
3. Identify policies and funding sources to support the expansion of CNM training in Maine, including through TMaH and RHTF.
4. Create a clinical training pathway by establishing and strengthening affiliation agreements between clinical sites, such as hospitals and FQHCs, and out of state educational programs, such as Yale, Georgetown, Boston College and Frontier University.
5. Leverage programs such as Building ME Network/Consortium for Healthcare Education and Training (CHET) for the placement of students in clinical sites with the support of Clinician Nexus.
6. Secure funding for preceptors and student supports, which could include preceptor stipends and training, and student housing close to clinical training sites. (Appendix B)
7. Integrate regional simulation training and standardized didactics across Maine. Standardized didactics and simulation are a viable approach for moving work forward and would be needed to launch a fellowship and may also support a transition-to-practice model. A CNM with an education background with or without an academic partner could put together a microgrant proposal and receive some funding to design and create the content for CNM students rotating in rural Maine and/or new graduate onboarding.
8. Create a Maine-based fellowship or TTP model for new graduate CNMs. A fellowship or TTP model would allow new graduates to gain additional clinical experience at a higher volume location and provide mentorship as they transition to independent practice.

APPENDIX A: SURVEY ANALYSIS: CERTIFIED NURSE MIDWIVES (CNMS) IN MAINE HOSPITALS

Survey Participation:
- Total responses: 11 hospitals
 - Employing CNMs: 9 hospitals (82%)
 - Not employing CNMs: 2 hospitals (18%)

Current CNM Workforce:
Total CNMs reported: 44 (employed + contracted/temporary)
 - Median number per hospital: 3
 - Highest reported: 10
Most hospitals that use CNMs employ only a handful, but there are a few larger employers with higher counts.

Training of Nurse Midwife Students:
- Currently training students: 5 hospitals

These sites actively take students, sometimes on a small scale (e.g., 4-5 students/year).
- ·Not training, but could/expressed interest: 6 hospitals

Even among those that answered "No," many provided notes showing capacity or interest but cited barriers such as:
-Limited patient volume to ensure a full range of experiences.
-Competing demands on CNM time (coverage, patient load).
-Lack of formalized arrangements with training programs.
-Administrative or policy hurdles ("not broached before").

Nearly all hospitals are either training or open to training, meaning with support for capacity-building, Maine could significantly expand its CNM training pipeline.

Hiring & Workforce Needs:
Most respondents are not actively hiring CNMs
 - 1 site noted possible need for 1-2 CNMs (not actively recruiting)
 - 1 site reported need for 3 inpatient midwives
 While most feel "fully staffed," there are clear pockets of unmet demand.

**Additional Insights- Expansion of midwifery services is viewed as valuable but constrained by staffing shortages and training opportunities. Several respondents highlighted the need for more birthing providers statewide. CNMs are generally well integrated with physicians and family practitioners

APPENDIX A: SURVEY ANALYSIS: CERTIFIED NURSE MIDWIVES (CNMS) IN MAINE HOSPITALS

Scope of Practice:

- Strong autonomy: ~78% of hospitals with CNMs report they practice fully independently (prescribe, bill, practice at top of license, considered medical staff).
- Partial autonomy: 1 hospital requires physician co-signature; CNMs are not full medical staff but part of Allied Health.
- No CNMs: 2 hospitals do not employ CNMs, relying instead on family physicians or not offering OB services.

Policy standardization across hospitals could eliminate the small but significant practice restrictions that limit CNM autonomy.

Opportunities for Expansion:

1. Statewide training program: Centralized or regional rotations could address volume concerns. There is strong hidden capacity–over half of the hospitals not training today could do so if barriers were reduced. This suggests an opportunity for statewide coordination.
2. Shared precepting models: Allowing cross-hospital support to ease pressure on small teams.
3. Policy alignment: Standardizing credentialing to maximize full scope practice. Most CNMs in Maine hospitals enjoy full practice authority, aligning with national best practices. A small minority face institutional limitations (co-sign requirements).
4. Targeted recruitment: Rural hospitals (those without CNMs or citing demand) are prime opportunities for workforce growth.

APPENDIX B:

The **Consortium for Healthcare Education** and the Building-ME Network are offering **microgrants** to increase the number of healthcare students being educated and trained in rural Maine communities.

Funding Categories:
Funds can support a variety of needs including healthcare education/training program creation or expansion, equipment, short-term housing, mileage-students or preceptors, preceptor stipends, community engagement efforts to help recruit learners to work in a specific rural community, and/or preceptor education/development.

To apply, please

1. Complete the **Microgrant Application Form**
2. 👉 https://forms.office.com/r/2rrnV0MAWm
3. Email a simple Excel budget with your organization name in the file name to:
4. Meredith Bullard, Program Manager, meredith.bullard@mainehealth.org

The Microgrant Application Form will request the following information:

- Organization Name, address, contact name and email
- Requested funding amount
- Brief summary of your request, including problem to be addressed, planned use of funds, and expected outcomes/impact
- Healthcare Learner discipline(s) who will benefit
- Funding categories (see list above)
- Date budget was submitted via email

Applications will be reviewed on a rolling basis while funds remain available. First review will occur after 11/1. We look forward to your application and to supporting the growth of clinical healthcare education and training opportunities across rural Maine.