



AB 2682 (Burke) Improving Access to Quality Maternity Care

The Problem

California and the United States face an urgent maternity care crisis that will harm more women if we don't act.

- The maternal death rate in the United States ranks the worst among all developed countries.¹
- In California, Black women are still dying at a rate 3 to 4 times that of White women.²
- Cesarean section is now the most common hospital surgery.³ Unnecessary cesarean carries significant potential harm, such as the step-wise increase in the risk of catastrophic hemorrhage with each subsequent cesarean.⁴
- The epidemic of preterm birth is increasing in California.⁵ Prematurity is the leading cause of death of children under 5, and often leads to lifelong disability and developmental delay.⁶

California faces a severe shortage of OB-GYNs throughout the state, which is projected to worsen.

- 9 counties have no OB-GYN⁷
- 19 counties have 5 or fewer OB-GYNs⁸
- There has been no increase in the number of OB-GYNs trained since 1980 despite a projected increase of 22% in California's female population by 2030.⁷

Better Access to Nurse-Midwives: A Key Strategy for Improving Outcomes

A certified nurse-midwife (CNM) is an individual licensed by the Board of Registered Nursing to provide well-woman care, family planning, as well as maternity care (before, during and after childbirth). Nurse-midwives work in hospitals, medical offices, clinics, birth centers, and homes.⁹

CNMs are educated in Master's degree nursing programs and are categorized as "advanced practice registered nurses" (APRN).⁹

CNMs attend approximately 11% of the vaginal births in California, with ninety-five percent of all CNM-attended births taking place in a hospital setting.¹⁰

Research demonstrates that nurse-midwives are an essential part of high-value, high-quality women's health care. The safety and quality of care by Certified Nurse-Midwives is indisputable. CNMs in the United States are among the most educated and experienced midwives in the world, exceeding international standards for midwifery competencies and standards of practice.¹¹ Midwifery care has been shown to *decrease the rates of*¹²:

- cesarean deliveries
- stillbirth and maternal mortality
- severe perineal trauma (birth trauma)
- severe blood loss
- preterm births
- newborns with low birthweight
- newborn admissions to neonatal intensive care units.

Current California Law Limits Access to Affordable, Safe Care Options for Women

In California, a CNM must practice under the "supervision" of a physician.

California is one of **only five states** with this provision.

According to current law, supervision “shall not be construed to require the physical presence of the supervising physician” (B&P Code 2746.5). Therefore, supervision consists of **none** of the following:

- Direct patient care or physical presence of the physician during clinic visits, birth, or hospitalization.
- Physician evaluation of CNM patients at any point during pregnancy or well-woman care
- Physician inspection or review of charts
- Physician discussion of patient care with CNMs
- Physician co-signature on prescriptions

The law thereby tethers CNMs geographically and economically to where obstetricians already practice, without providing any actual oversight or safer care.¹³ Rural areas and health provider shortage areas (HPSAs) are suffering the consequences. This harms women.^{14,15}

Untethering CNMs from physician supervision requirements will promote the expansion of health care access for thousands of women in both urban and rural communities. **CNMs will continue to participate in collaborative team-based care, expertly co-manage patient care with obstetricians when the woman’s condition indicates that she is no longer “low-risk,”** and safely and appropriately transfer care to the obstetrician (without delay) when the woman’s condition warrants such a transfer.

What Evidence Supports Removing Physician Supervision to Improve Access and Outcomes?

A robust collection of studies looking at state regulatory environments for nurse-midwives provides a compelling argument for removal of physician supervision as an important *first step* in improving health outcomes and increasing access to care.

- Women in states with independent nurse-midwifery practice have lower odds of cesarean delivery, preterm birth, and low birth weight infants.¹⁶
- States that promote and integrate midwives into their systems of care have better infant and maternal outcomes; conversely, states with the most restrictive practice environments for nurse-midwives (e.g. less independent practice, restricted scope of practice) score worse on critical maternal and infant health indicators (cesarean, preterm birth, neonatal mortality).¹⁷
- States where midwives have independent practice have a higher proportion of CNM attended births in rural hospitals.¹⁸
- States with regulations that support independent practice have a larger CNM workforce, and a greater proportion of CNM-attended births.¹⁶
- The single best predictor of distribution of nurse-midwives in a state is the degree to which midwifery practice is restricted.¹⁹
- Economic analyses demonstrate the feasibility of removal of supervision as a realistic method of reducing the maternity workforce shortage while simultaneously increasing health care savings.²⁰
- **Specifically in California**, compared to primary care physicians, nurse-midwives have a greater proportion of members in rural and health provider shortage areas.²¹

Lower cost for excellent results. CNMs have phenomenal maternity care outcomes that include fewer cesarean deliveries. Cesarean deliveries put women at increased risk for hemorrhage, infection, deep vein thrombosis, and postpartum depression. Possible long-term complications from cesareans include infertility, complications in subsequent pregnancies, and hysterectomy.⁴ Cesareans are expensive to perform and result in longer hospital stays. Studies show that CNM-attended births are 25% more likely to avoid a cesarean.^{22,23} Reducing cesareans would save the California medical system \$80 million to \$440 million per year.³ This is only one of the many cost-saving outcomes of CNM care. CNM care is also associated with fewer preterm births, newborns with low birthweight, newborn admissions to neonatal intensive care units, and maternal hemorrhage.¹³

According to the Center for Disease Control and Prevention, there were 494,705 total births in California in 2013 of which 1,365 were in free-standing birth centers serviced by CNMs. At a savings of \$1163 per birth,²⁴ CNMs providing care in birth centers save \$1.6 million dollars annually in California. Consumer interest in birth centers is rising.²⁵ When 1% of births take place in a birth center, it is projected that \$5.8 million will be saved in California alone. As an innovation in

health care delivery to low-risk childbearing women and families, nurse-midwives practicing in birth centers ensure core principles of prevention, sensitivity, safety, appropriate intervention, and cost effectiveness.

Consistency. In 2013, the legislature removed the physician supervision requirement for Licensed Midwives (LMs), who are licensed and regulated by the Medical Board of California (AB 1308; Bonilla Chapter 665 Statutes of 2013). Licensed primarily work in the home and birth centers, are not required to have an RN license, and are not bound by the same extensive educational requirements as nurse-midwives. For purposes of consistency and simple common sense, nurse-midwives must be untethered from physician supervision.

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- 1 Martin N. A Larger Role for Midwives Could Improve Deficient U.S. Care for Mothers and Babies. *ProPublica*. February 22, 2018. <https://www.propublica.org/article/midwives-study-maternal-neonatal-care>. Accessed March 1, 2018
- 2 Martin N, Montagne, R. Nothing Protects Black Women From Dying in Pregnancy and Childbirth. *ProPublica*. December 7, 2017. <https://www.propublica.org/article/nothing-protects-black-women-from-dying-in-pregnancy-and-childbirth>. Accessed March 1, 2018.
- 3 Smith H, Peterson N, Lagrew D, Main E. 2016. Toolkit to Support Vaginal Birth and Reduce Primary Cesareans: A Quality Improvement Toolkit. Stanford, CA: California Maternal Quality Care Collaborative
- 4 Main E, Morton C, Hopkins D, Giuliani G, Melsop K, Gould J. Cesarean Deliveries, Outcomes, and Opportunities for Change in California: Toward a Public Agenda for Maternity Care Safety and Policy. Palo Alto, CA: California Maternal Quality Care Collaborative; 2011.
- 5 Sullivan, M. Preterm Birth Rates are Rising in California after Years of Decline. *The Sacramento Bee*. Nov 1, 2017. <http://www.sacbee.com/news/local/health-and-medicine/article182067106.html>. Accessed March 1, 2018.
- 6 March of Dimes. Long Term Health Effects of Premature Birth. <https://www.marchofdimes.org/baby/long-term-health-effects-of-premature-birth.aspx>. Accessed March 1, 2018.
- 7 American College of Obstetricians and Gynecologists. 2014 Workforce Fact Sheet: California. <http://california.midwife.org/california/files/ccLibraryFiles/Filename/000000000290/CAACOGworkforce2014revised.pdf>. Accessed March 1, 2018.
- 8 Canto M. Despite Dire OB-GYN Shortage, Lawmakers Won't Expand Role of Nurse-Midwives. *CalMatters*. September 7, 2016. <https://calmatters.org/articles/state-faces-dire-ob-gyn-shortage-but-lawmakers-wont-expand-role-of-nurse-midwives/> Accessed March 1, 2018
- 9 American College of Nurse-Midwives. Essential Facts about Nurse-Midwives. <http://midwife.org/essential-facts-about-midwives>. Accessed March 1, 2018.
- 10 California Nurse-Midwives Association. Certified Nurse-Midwives in California Fact Sheet. <http://california.midwife.org/california/files/ccLibraryFiles/Filename/000000000247/CNMFactSheet2014.pdf>. Accessed March 1, 2018.
- 11 American College of Nurse-Midwives. Definition of Midwifery and Scope of Practice of Certified Nurse-Midwives. <http://www.midwife.org/Our-Scope-of-Practice>. Retrieved March 1, 2018
- 12 Ten hoop-bender P, De bernis L, Campbell J, et al. Improvement of maternal and newborn health through midwifery. *Lancet*. 2014;384(9949):1226-35.
- 13 California Board of Registered Nursing. Sunset Review Report 2014. p. 200.
- 14 Maron D. Maternal Health Care is Disappearing in Rural America. *Scientific American*. February 15, 2017. <https://www.scientificamerican.com/article/maternal-health-care-is-disappearing-in-rural-america/> Accessed March 1, 2018.
- 15 Kozhimannil K. Rural America's Disappearing Maternity Care. *The Washington Post*. November 8, 2017. https://www.washingtonpost.com/opinions/rural-americas-disappearing-maternity-care/2017/11/08/11a664d6-97e6-11e7-b569-3360011663b4_story.html?utm_term=.de9a343a79d5 Accessed March 1, 2018.
- 16 Yang YT, Attanasio LB, Kozhimannil KB. State Scope of Practice Laws, Nurse-Midwifery Workforce, and Childbirth Procedures and Outcomes. *Womens Health Issues*. 2016;26(3):262-7.
- 17 Vedam, S., et al. (2018). "Mapping integration of midwives across the United States: Impact on access, equity, and outcomes." *PLoS One* 13(2): e0192523.
- 18 Kozhimannil, K. B., et al. (2016). "The Practice of Midwifery in Rural US Hospitals." *J Midwifery Womens Health* 61(4): 411-418.
- 19 Declercq, E. R., et al. (1998). "State regulation, payment policies, and nurse-midwife services." *Health Aff (Millwood)* 17(2): 190-200
- 20 Conover C, Richards R. Economic benefits of less restrictive regulation of advanced practice nurses in North Carolina. *Nurs Outlook*. 2015 Sep-Oct;63(5):585-92.
- 21 Grumbach, K., et al. (2003). "Who is caring for the underserved? A comparison of primary care physicians and nonphysician clinicians in California and Washington." *Ann Fam Med* 1(2): 97-104
- 22 Cragin L, Kennedy HP. Linking obstetric and midwifery practice with optimal outcomes. *Journal of Obstetrical, Gynecological, and Neonatal Nursing*. 2006;35:779-785.
- 23 Rosenblatt RA, Dobie SA, Hart LG, et al. Interspecialty differences in the obstetric care of low-risk women. *American Journal of Public Health*. 1997;87:344-351
- 24 Howell, E., Palmer, A., Benatar, S., Bowen, G. Potential Medicaid cost savings from maternity care based in a freestanding birth center. *Medicare and Medicaid Research Review*. 2014: 4(3).
- 25 MacDorman, MF., Mathews, MS., and Declercq, E. Trends in Out-of-Hospital Births in the United States, 1990-2012. *NCHS Data Brief*, Number 144, March 2014