Insert Date

[insert name of Assemblymember/Senator]

[Insert address of your representative’s State Capitol office]

Re: AB-2682 (Burke) – SUPPORT

Dear Assemblymember/Senator [insert name]:

I am a practicing physician in the state of California and I am writing to request your support for AB-2682 (Burke). Passage of AB-2682 will improve health outcomes for women and babies, increase access to high quality women’s health care, and permit women to choose for themselves their preferred reproductive health providers.

***California and the United States face an urgent maternity care crisis that we must immediately begin to remedy*.** There is now strong, mounting evidence that greater access to nurse-midwifery care is a critical strategy to curbing this crisis.

The maternal mortality rate in the United States ranks the worst among all developed countries, and is still increasing.1 Even in California where we have bucked the national trend with maternal mortality, Black women still die at a rate 3 to 4 times that of White women.2 Cesarean section is now the most common hospital surgery, with roughly 33% women in California and the United States giving birth by major abdominal surgery.3 We know that potentially half of cesarean births may be unnecessary.4 These unnecessary procedures carry significant potential harm for mothers and babies, such as the step-wise increase in the risk of catastrophic hemorrhage with each subsequent cesarean.5 With 160,000 cesarean births in California each year, the cost adds up in both health care dollars spent and in lives permanently affected.

While there are many contributing factors to this absolute crisis, expanding and improving the maternity care workforce must be an essential strategy. In California, we currently face a severe shortage of obstetrician-gynecologists (OB GYNs). There are 9 California counties without an obstetrician6 and the Medical Board of California notes that nineteen California counties have five or fewer OB-GYNs. This scarcity of obstetricians is projected to worsen.

The safety and quality of midwifery care is indisputable.7 Nurse-midwives in the United States are among the most educated and experienced in the world, exceeding international standards for midwifery competencies and standards of practice.8 Midwifery care has be shown to *decrease the rates* of7:

* 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.

Nurse-midwives attend approximately 11% of the vaginal births in California, with 95% of all CNM-attended births taking place in a hospital setting. In California, a woman’s ability to access a nurse-midwife is limited in part because nurse-midwives must practice under the “supervision” of a physician. Because California law is ambiguous about how “supervision” should be conducted, supervision occurs in word only but not in actual practice. Physicians are not required to be physically present during clinic visits, births or hospitalizations. ***The law thereby tethers CNMs geographically and economically to where obstetricians already practice, without providing any actual oversight.***This significantly restricts access to women’s health care without showing any benefit to patient safety.9 Currently, ***California is one of only five states that still requires physician supervision.***

Of note, in 2013, the state legislature removed physician supervision requirements for licensed midwives. Licensed midwives mostly attend births at home, but do not have an RN license and are not otherwise bound to similar educational requirements for nurse-midwives. ***For purposes of equity and simple common sense, nurse-midwives in California should be similarly untethered from physician supervision.***

Under AB-2682, nurse-midwives will continue to participate in collaborative team-based care with obstetricians, will continue to consult their obstetrician colleagues, will expertly co-manage 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. This ability to co-manage and/or transfer care when a patient falls outside of the nurse-midwife’s scope of practice is a fundamental competency of the art and science of nurse-midwifery. Furthermore, nurse-midwives value and trust the opinion and care given by their physician colleagues. This relationship will be strengthened with the passage of AB 2682.

For those who doubt midwives can curb the maternity care access and workforce crisis, 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 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.10
* 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).11
* States where midwives have independent practice have a higher proportion of nurse-midwife attended births in rural hospitals.12
* States with regulations that support independent practice have a larger nurse-midwifery workforce, and a greater proportion of CNM-attended births.10
* The single best predictor of distribution of nurse-midwives in state is the degree to which midwifery practice is restricted.13
* 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.14
* **Specifically in California,** compared to primary care physicians, nurse-midwives have a greater proportion of members in rural and health provider shortage areas.15

Help us serve our communities by supporting a strong partnership between obstetricians and nurse-midwives while simultaneously improving access to women’s health care. ***The health care needs in our state are too great to continue supporting antiquated policies that are not evidence-based.*** Our current maternity care crisis necessitates your immediate action.

Please vote yes on AB-2682.

Sincerely,

[sign name here]

[type name and credentials here]

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<http://california.midwife.org/california/files/ccLibraryFiles/Filename/000000000290/CAACOGworkforce2014revised.pdf>. Accessed March 1, 2018.

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13 Declercq, E. R., et al. (1998). "State regulation, payment policies, and nurse-midwife services." Health Aff (Millwood) 17(2): 190-200

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15 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

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