House Families, Aging, and Human Services Committee

Chairwoman Manchester

May 19, 2022

Chairwoman Manchester, Vice Chair Cutrona, Ranking Member Denson, and Members of the House Families, Aging, and Human Services Committee – thank you for allowing me to provide proponent testimony today on House Bill 496.

My name is Lauren Genter and I'm a Certified Professional Midwife with my Bridge Certificate. I run an independent home birth practice based in Athens County, Ohio. I serve both Amish and non-Amish ("English") families in my mostly rural practice.

Southeast Ohio is home to some of the most rural and impoverished counties in our state. Many people in our area live far from even basic services. Three of the counties I commonly serve rank among the worst in the state with poverty rates over 30%. Many families I serve there essentially live in what you might call a pregnancy care desert. The nearest place for routine prenatal care is close to an hour away by car for some families. This is an obstacle that absolutely creates a barrier to routine pregnancy and preventative care for rural families. This is especially true for the Amish, a community of people who do not use cars and have to hire drivers to get to medical appointments. These communities rely almost completely on in-home care from midwives like me to catch problems and refer them to appropriate providers should a problem arise. And yet, in Ohio we midwives have no legally protected access to the tests, ultrasounds, and professional referral network necessary to do our jobs. Many of us have spent years building mutual respect in our local medical communities to be able to have the most basic level of professionalism afforded us. And still, some of us face barriers (and sometimes open hostility) should we need to transfer a patient to a hospital, and it's the expectant families who suffer most. I'd like to offer a true case story to illustrate the thoroughness of typical midwifery care and the barriers we face.

A few years ago, a young Amish family pregnant with their first baby, hired me to be their midwife. They contacted me around 12 weeks gestation and had their first prenatal appointment around 14 weeks. Her prenatal care was typical of what CPMs provide for every client. At her visits we discussed her health and medical history in detail, we reviewed nutrition and what supplements and medications she was taking and made recommendations, we discussed her sleep, her emotional state, testing options, made a plan for her to obtain basic pregnancy lab work, and discussed and signed informed disclosure and consent to care documents. She was provided my detailed practice guidelines and protocols and other informational documents. She was given time to ask and get answers to any questions or concerns she had. We discussed standard pregnancy testing that was appropriate at each stage and she was given options to obtain these if she desired. We developed a detailed emergency plan should she need to transfer for any reason. I also provided routine prenatal care at each visit, assessing a number of clinical markers to monitor the health of the mother and baby. Each visit lasted at least an hour in her home.

Following the typical schedule of care, I saw her for monthly hour long visits in her home throughout her second trimester. In the third trimester, we started having visits every two weeks, then finally as she approached full term, a visit once a week to keep close tabs on the status and health of both mother and baby. By the time she went into labor, this particular woman had had 11 prenatal visits each over an hour, which is about average for my clients. In active labor, she developed a non-emergent concern. We never-the-less felt it would be more prudent if it was handled in a hospital setting. The hospital that knows me best was about an hour from her home so following her transport plan, we went to a different, closer hospital, 30 minutes from her home that doesn't know me well. Upon arrival, I transferred her complete prenatal records, medical history, lab work, and labor records to the hospital, a document of complete records 17 pages long. Unfortunately, multiple times my attempts to communicate with the staff at this facility went disregarded. Though I clearly stated the concern and reason for our transfer to the staff, they ignored my report on her condition until hours later they came to the same conclusion themselves and at that time, again hours later, initiated the appropriate treatment. As is my protocol, I stayed with the family a couple hours after the birth of the baby (I had been with them for about 20 hours at this point) and was getting ready to say goodbye when I overheard one nurse giving report to another nurse about my client at shift change, she said "...24 years old, no prenatal care."

Needless to say I haven't forgotten that moment though it was a few years ago now. Instead of a spirit of collaboration, the staff chose to disregard this woman's chosen primary provider and all the information they received from that provider about her health, history, prenatal care, pregnancy, and labor. In doing so, they jeopardized the optimal care of the mother and baby. While I feel lucky that this isn't a typical scenario for me (I don't usually transfer to that particular hospital) and I do have a places where my clients and I can go and be respected and heard, it does show that it certainly isn't guaranteed for me or any other midwife in this state without official recognition. I reiterate again, it is the birthing families who suffer most in these dismissive and derisive situations. It is well documented that the integration of midwifery improves maternal and infant outcomes. Maternal and perinatal outcomes are also better in places where midwives are regulated and have legislative authority to practice to their full scope, including collaborating with other health professionals [1].

The midwifery model not only provides exceptional and comprehensive care for pregnancy and birth as already described but also for vulnerable postpartum parents and their babies. In the first week postpartum we typically offer two in-person postpartum visits, then postpartum and well baby visits at 2, 4, and 6 weeks after the birth. At these visits we screen for any physical or emotional problems (for example: pre-eclampsia and postpartum depression), we provide essential newborn screenings, give information, discuss breastfeeding, and offer referrals to specialists as needed. For many of the families I serve in my rural area, I may be the only healthcare professional providing care for these parents and babies in the postpartum.

One particular community I serve is an hour from <u>any</u> hospital. And there are zero hospitals in the entire Southeast region of Ohio that have any more than a level 1 NICU to care for babies that need extra care. It is imperative that families in these rural care deserts have access to midwives and especially licensed midwives that can provide routine and essential pregnancy related diagnostics such as lab work, ultrasounds, and referrals, in addition to life-saving emergency medications, when appropriate. Thank you for hearing my testimony and for

supporting this common sense regulation and licensing of the work already being done by Certified Professional Midwives in our state.

[1]. Vedam, Saraswathi et al. “Mapping integration of midwives across the United States: Impact on access, equity, and outcomes.” *PloS one* vol. 13,2 e0192523. 21 Feb. 2018, doi:10.1371/journal.pone.0192523