23 January 2024

Esteemed members of the HCIFS Committee:

I write to you not only as an affected party of this bill, being a Certified Professional Midwife licensed in Maine, but also as a data scientist with a doctoral degree in sociology and a deep respect for the need for efficient, usable, and equitable data collection on perinatal practices and outcomes in the state of Maine. Because of the apparent flaws in the current proposition, I advocate for a vote of **ought not pass** on LD1205 in its current state for the reasons outlined below.

LD1205 betrays the goal of equitable data collection for quality improvement by moving in a distinctly exclusive and punitive direction.

Attaching the names and license numbers of CPMs, CMs, and receiving providers as well as specific cases to data points implies that midwives licensed under the Board of Complementary Healthcare Providers should receive more intense, direct scrutiny than other perinatal providers and should be held accountable to disciplinary avenues beyond the functioning system already in place within the governing board. These requirements are notably not being suggested for other types of perinatal healthcare providers in Maine, despite the fact that many different providers participate in provider-to-provider transfers of care - which seems to be the focal point of LD1205's plan.

Data reporting to the governing board is already required annually for midwives licensed under the Board of Complementary Healthcare Providers. For those seeking to engage with this data, anonymized and aggregated versions are available upon request. Case review opportunities also exist throughout the state of Maine and can be initiated by anyone involved in a case via the Perinatal Transitions Program and/or the Board of Complementary Healthcare Providers. The Board that governs licensed midwives has disciplinary protocols in place to be used as necessary and, as such, the inclusion of license numbers and specific cases to data reporting to the DHHS is unnecessary at best and does not represent best practices for collecting and analyzing data for quality improvement or policy guidance. Moreover, moving data reporting from the Board that governs licensed midwives to the DHHS threatens the autonomy of an entire group of healthcare professionals who already function with a system of governance.

Creating this data reporting burden on CPMs and CMs alone does not further the goal of *equitably* collecting state-wide data on perinatal outcomes as its target is narrow and exclusive. LD1205's plan would fail to collect data from other licensed professionals who are practicing in the community setting, as are CNMs and OBs in the state of Maine, as well as licensed professionals practicing in the perinatal field in other (namely hospital) settings. This version of data collection can only be interpreted as a means of targeting the licensed professionals named in the bill at the expense of DHHS resources.

LD1205's plan would create an undue administrative and financial burden on the state.

Maine CPMs and CMs who attend community birth already participate in birth certificate filing via the DAVE system, which collects information on most of the proposed categories. As with annual reporting to the Board, vital statistics information is available upon request via the Maine CDC. This plan creates redundancies in the system when much of the proposed data is already collected via birth certificate reporting. DHHS will bear the administrative and financial

burden of implementing this plan, as it requires either an expansion of or a new pathway under the DAVE system.

Making data publicly available involves dedicated staff for data aggregation, report production, and request processing. These are all very necessary tasks that are currently being completed by the Maine CDC and the Board of Complementary Healthcare Providers, and to add yet another requirement for data reporting and dissemination would create a redundancy not only at the system level but also at the staffing level of DHHS.

Further, adding categories and variables to DAVE reporting does *not* require opening the statutes governing CPMs and CMs, as this would ideally be a community-wide requirement similar to the recent DAVE updates to include new questions on substance use history during birth certificate filing - which, as a reminder, accrued a cost of $24,000 to implement. If the committee sees a need to change data reporting protocols regarding birth certificate filing, that should decidedly not be held under the statutes of one specific category of providers.

LD1205 endangers data integrity and the application of statistics for improving healthcare quality, determining scope of practice, and enacting perinatal health policy.

Every change or addition to a data collection protocol creates challenges in continuity and data usage. If this plan is implemented, it will effectively result in the creation of multiple incongruous data sets that will confound statistical analyses and potentially create setbacks in our attempts to use population-level data to inform analyses of challenges in perinatal healthcare. The lack of standardization across datasets hinders goals of improving healthcare quality, determining scope of practice, and informing healthcare policy.

Recall the issues the CDC recently faced in amending vital statistics reporting of birth setting to incorporate planned location of birth and the prior misattribution of certain outcomes, like cesareans, to only hospital settings - a massive undertaking that has served as a significant course-correct for all types of providers in what was very flawed data collection, but has been a cumbersome and costly change. The data that predates this change is, in many ways, incomparable to the data that we are able to collect via birth certificate reporting now. If we are to support a shift in data reporting, it should truly be to clarify and enhance the datasets we will create in the future. LD1205 has not demonstrated that its plan will further clarity, consistency, or usefulness, and could instead be simply a large and arduous undertaking that results in more confusion and less usable data.

Data collection is central to our ongoing project to improve perinatal healthcare in the state of Maine, and both consumers and providers deserve a standardized, modernized, and unbiased system for this endeavor. A better path forward for data collection involves both streamlining and aligning avenues for reporting *and* including all perinatal healthcare providers in reporting requirements to avoid the burdens outlined above. Because LD1205 fails to meet these goals, I ask the members of this committee to oppose its passage at this time.

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