MIDWIVES ADVISORY COMMITTEE
Professional & Vocational Licensing Division
Department of Commerce & Consumer Affairs
State of Hawaii

MINUTES OF MIDWIVES ADVISORY COMMITTEE MEETING

The agenda for this meeting was filed with the Office of the Lieutenant Governor as required by section 92-7(b), Hawaii Revised Statutes.

Date: Monday, March 4, 2024

Time: 9:00 a.m.

In-Person Meeting Location: Queen Liliuokalani Conference Room
HRH King Kalakaua Building, 1st Floor
335 Merchant Street
Honolulu, Hawaii 96813

Virtual: Virtual Videoconference Meeting – Zoom Webinar (use link below)
https://dcca-hawaii-gov.zoom.us/j/82798754324

Zoom Phone Number: (669) 900 6833
Meeting ID: 827 9875 4324

Zoom Recording Link: https://www.youtube.com/watch?v=pOewHt6ZxWA

Virtual Meeting Instructions: Sheena Kristie Duarte provided information on internet and phone access for today's virtual meeting and a short video regarding virtual meetings was played for attendees.

For purposes of this virtual meeting, the EO will take roll call of the Committee members to establish quorum and for motions that require a vote of the Committee members.

Members Present:
Lea T. Minton, CNM
Sheena Kristie Duarte, Public Member
Leah Hatcher, CPM
Rachel Lea Curnel Struempf, CPM
Pua O Eleili Pinto, Public Member
Whitney Herrelson, CPM

Staff Present:
Lee Ann Teshima, Executive Officer ("EO Teshima")
Alexander Pang, Executive Officer ("EO Pang")
Shari Wong, Deputy Attorney General ("DAG Wong")
Marc Yoshimura, Secretary

Attendees:

Laura Acasio
Rebekah Botello
Margaret Ragen, CM, LM, MS
Pacific Birth Collective (Kiana Rowley)
Tara Compehos
Laulani Teale
Rep. Natalia Hussey-Burdick
Melissa Danielle
Kris
Piper Lovemore (she/they/auntie)
JmeLee Lewis
Sara Kahele
Tabby
Daniela Martinez
Zoom user
Pahnelopi McKenzie
Morea Mendoza
Carol Velasquez
Kaaumoana
wyonettewallett
Makiilei
Lara Goldsmith
A. Ezinne Dawson, CPM, LM

Call to Order:

The agenda for this meeting was filed with the Office of the Lieutenant Governor, as required by section 92-7(b), Hawaii Revised Statutes ("HRS").

EO Teshima took roll call and asked the Committee members if they were alone in a non-public location. The meeting was called to order at 9:08 a.m.

Approval of January 29, 2024 Meeting Minutes:

EO Teshima asked if the Committee had any corrections, questions, or discussion on the January 29, 2024 Committee meeting minutes. Seeing none, EO Teshima asked if anyone from the public wished to testify on the minutes.

Margaret Ragen raised her hand and was promoted to panelist. Ms. Ragen stated that on last meeting's agenda, it was noted that her submissions would have been discussed, they did run out of time which did not enable them to discuss submissions regarding the CM credential. She was hoping to have an opportunity today to speak. She understands there's a lot going on, but it is important to not have the CM be lost.

Laulani Teale raised her hand and was promoted to panelist. She requested that the draft meeting minutes be posted along with the items so they can be reviewed because we don't have access to them, so we can't really comment on them

because we don't have access. It's important that these be made available to the public.

EO Teshima noted that right after the Committee meetings, the recording of the "minutes" is posted on the Midwives webpage for everyone to listen to. We have to get a hardcopy for the Committee to review within 30-40 days. Ms. Teale asked, do you mean the Zoom video, because that's not what she means by the "minutes." EO Teshima replied, that is the "minutes," and the Committee reviews the hardcopy which is pretty much from the recording. Ms. Teale said that she's asking that the hardcopy be made available to the public. Ms. Struempf asked, can it be made available before it's approved? EO Teshima replied, it can be a draft – we'll try to get that out, but it is a workload issue for us with our multiple meetings, so we'll try to get that out before the next scheduled meeting. Ms. Teale said, just so we can see what's being approved because she thinks it's a requirement.

Ms. Struempf moved to approve the minutes as circulated. Ms. Duarte seconded. EO Teshima asked for any nays, abstentions, or reservations. Seeing none, the January 29, 2024 Committee Meeting Minutes were approved as circulated.

EO's Report: **2024 Legislative Session**

EO Teshima stated that, from her last check online, she did not see any of the midwives bills moving forward.

Ms. Duarte stated, just wanted to make a note that HB 955 is still allowed to be rereferred out of committee until Thursday, March 7, so that could still be used as a vehicle. EO Teshima asked, do you know which committee it has to go to? Ms. Duarte replied, it has to be rereferred out of Finance. It has to be brought to the floor, in a House floor hearing which only happens Tuesday and Thursday, and then voted on.

Ms. Teale raised her hand and was promoted to panelist. She stated: since HB 955 is the last measure, if it does not pass, she just wants to reiterate the importance of DCCA issuing a moratorium which is within its power. She did submit a short moratorium at the last meeting, which just says: *Act 32, 2019 states: "Nothing in this chapter abridges, limits or changes in any way, the right of parents to deliver their baby where, when, how and with whom they choose, regardless of licensure under this chapter." A moratorium on enforcement against any practitioner whose participation in birth work is necessary to uphold this provision, or to ensure safety in any community birth setting, or to perpetuate the practice of traditional Native Hawaiian healing, shall therefore be in effect until permanent rules for this chapter are established."* She wants to again recommend that that be considered by the Executive Officer for an administrative band-aid until we can figure something else out.

Laura Acasio raised her hand and was promoted to panelist. She recommended that this Board discuss HB 955 as a potential venue for solving much of the issues that are coming up around this definition and the interim rules. She also echoed the testimony of the previous speaker. She introduced herself as Laura Acasio, a former state senator for District 1.

Ms. Pinto stated that she is currently illegal as far as what the Attorney General said when she does any kind of birth-related education, especially because all of her birth work training is not from a licensed midwife but as her ʻōiwi culture aspect, and again she wants to clarify because people have confused with her license as a massage therapist, that she has nothing from her massage therapy school teaches people about prenatal care. Just having a license in massage therapy does not qualify you to be able to efficiently and safely touch a pregnant family, or to work with them. HB 955 would be one of those bills that would actually make her not be illegal anymore, and also that moratorium that Ms. Teale shared would also not make her illegal, as a Hawaiian illegal in Hawaii. Also, what she talked about last time, was that in 1863 her grandfather was a kahuna that was trying to be validated as a Hawaiian healer in the front of the Board of Health, and that still has not happened, as being a Hawaiian healer in Hawaii not valid to practice our culture as a healing entity around birth.

Ms. Struempf said she wasn't aware that there could be a moratorium filed by the DCCA, and asked, is that something we could do to resolve this oversight temporarily while we sort this out? EO Teshima said, it would be up to the Director's office. Ms. Struempf asked, how would we go about asking the Director? EO Teshima replied, we can present it to her, but it'll be up to her, and our AG would have to weigh in to see if it's legal or not. Ms. Struempf said that she would like to do that. EO Teshima replied, we will present this to the Director and find out.

Ms. Duarte said, since Laura brought up discussing, is there anything we can do as a Committee to make a motion to let the Legislature know that HB 955 is something we can vote on as a Committee for them to bring to the floor by Thursday? EO Teshima said, all of your recommendations as of now are in regards to the rules. Any recommendations will come out of the Director's Office.

Review and Discussion of Proposed Rules for License Midwives' Draft #3:

EO Teshima explained that the Committee members have receive draft 3 of the proposed rules. EO Teshima also sent the members a draft 4 on Friday, which was cleaner than draft 3. She deleted any duplicative definitions, meaning if it was already in HRS 457J, whether it was a definition, scope of practice, what midwives can administer to their patients, she deleted it from the rules, because it's already in the law. The purpose of the rules is to clarify the law, so there's no sense putting provisions in both places. She directed the Committee to review each member's comments on draft 3, and she would tell them if their comments were

addressed in draft 4. She began by letting Ms. Struempf discuss her comments and recommendations first.

Ms. Struempf's comments

Ms. Struempf said she does not feel comfortable voting on an incomplete document. She thinks that EO Teshima is trying to make it more easy for us, but that has made it more complicated and less clear on what exactly is in and not in the rule. She is really unhappy with draft 4. She went through and compared a line-by-line of drafts 3 and 4, and there's more changes than meets the eye. Under definitions, draft 4 is different from draft 3. You've taken out "midwife assistant," which is absolutely not cool because both Whitney and I at the last meeting said we use these people. You've taken out "midwife technical supportive services" and she understands that EO Teshima said that we don't have the statutory authority to make this work, but she disagrees. She's read the laws and did a lot of research and she doesn't believe that. Also, the definition of "midwifery" in draft 4 is not a definition, it's a run-on sentence that makes absolutely no sense whatsoever. It's defining what midwifery isn't, it's not a definition of what midwifery is.

Going to draft 4 under renewal and restoration of license, section c, illegal practitioner, what does that mean? That's new language to this draft, to all drafts. She cited the language in draft 4: *"(c) Any midwife who fails to renew a license as provided in section (a) but continues to practice shall be considered an illegal practitioner and shall be subject to the penalties provided for violation of this chapter."* She said, that's just new language, so she'd like clarification on what exactly that means.

Moving to "§16-121-5, Scope of practice," on draft 3, it says on paragraph 2, *"Practice as a licensed midwife includes but is not limited to observation, assessment, development, implementation, and evaluation of a plan of care; health counseling; supervision and teaching of other personnel; and teaching of individuals, families, and groups; provision of midwifery services via telehealth; administration, supervision, and teaching of other personnel; and teaching of individuals, families, and groups; provision of midwifery services via telehealth; administration, supervision, coordination, delegation, and evaluation of midwifery practice […]"* In draft 4, the word "supervision" has been removed and changed to "supervision of a student midwife," and "delegation" has been removed. Ms. Struempf said: what they're doing is, they've taken away "midwife assistant," taken away her ability to supervise and delegate. And this is really for the CMs, but they've done it again later for the CPM.

Moving further down in that same section, *"(b) Practice as a certified midwife means the full scope of midwifery, regardless of compensation or personal profit that incorporates caring for all clients in all settings and is guided by the scope of*

practice authorized by this chapter, the rules of the director, and midwifery standards established or recognized by the director […]" Ms. Struempf noted that "regardless of compensation or personal profit" was removed in draft 4, and that language was in there for a reason. She thinks the State is doing it to cover themselves about the lawsuit. She also noted that "the rules of the director, and midwifery standards established or recognized by the director" had been removed in draft 4, and also noted that this language is in all of the rules for all of the professions. Why is it being taken out of the midwifery rules? It doesn't make sense and it's not OK.

Continuing from that same subsection in draft 3, (b)(1) states: *"(1) Advanced assessment and the diagnosis, prescription, selection, and administration of therapeutic measures, including over the counter drugs; legend drugs; the provision of expedited partner therapy pursuant to section 453-52; and controlled substances within the licensed midwife's education, certification and role […]"* Ms. Struempf noted that "diagnosis" had been removed in draft 4, so now she is no longer able to diagnose her clients. She understands prescription is taken out, that has already been taken out. The CM, we've already established, has the same scope of practice as an APRN which is basically, you're taking away their ability to have expedited transfer of care or concurrent care or referrals, which means that for her, when she transfers a client, she has to send them to their PCP to get them to a specialist because she's low down on the totem pole, but the CM is high, they are equivalent to a physician's assistant. They should be able to directly refer their clients to a specialist without having to go through the middleman, your primary care physician. By taking out the provision of expedited partner therapy, you are putting the middleman back into their scope of practice, which is not allowing them to practice to the full scope of their training.

Moving down to subsection (c) in draft 3: *"(c) Practice as a certified professional midwife means the full scope of midwifery, regardless of compensation or personal profit, that incorporates caring for all clients in all settings and is guided by the scope of practice authorized by this chapter, the rules of the director, and midwifery standards established or recognized by the director including but not limited to: (1) Advanced assessment and the diagnosis, selection, and administration of therapeutic measures according to the limited formulary of this chapter within the certified professional midwife's education, certification and role; and"* Ms. Struempf noted that again, "regardless of compensation or personal profit" and "the rules of the director, and midwifery standards established or recognized by the director" had been removed in draft 4. That is standard language in all of the regulated professions, and so that should be left in there. In subsection (c)(1), "diagnosis" was taken out in draft 4. Ms. Struempf asked, how am I supposed to treat somebody if I cannot diagnose them? In the law, in 457J, it says that she is allowed to run diagnostic tests, but in this, she's not allowed to diagnose somebody? It's not congruous. Pursuant to Section 457J, she is

allowed to diagnose her clients, but this is taking out all reference to her being able to diagnose anyone in any way, shape, or form.

Moving down to subsection (d)(4) in draft 3: *"(d) The practice of midwifery is based on and is consistent with a licensed midwife's education and national certification including but not limited to: […] (4) Ordering, interpreting, and performing diagnostic, screening, and therapeutic examinations, tests and procedures […]"* Again, "diagnostic" has been removed in draft 4. Subsection (d)(5), *"Formulating a diagnosis;"* has been removed from draft 4 in its entirety. Again, this is in 457J. That is not acceptable. Ms. Struempf asked, if I run a pap smear, which is well woman care, how am I not allowed to diagnose them with vaginosis or venereal warts or gonorrhea? That's a diagnosis.

Moving down to subsection (d)(13) in draft 3, which states: *"(13) Participating in joint and periodic evaluation of services rendered such as peer review, including chart reviews, case reviews, client evaluations, and outcome of case statistics; […]"* Ms. Struempf asked what the State means by "chart reviews," she doesn't know what that means. She asked, do doctors do chart reviews? That seems like a HIPAA violation. She understands peer review, statistical data collection, outcome collection, but why do you need to look at her charts? That seems very interesting. She wants to know what that means, and why.

Moving down in draft 3 to §16-121-6, Care provided by licensed midwives: *"(a) Licensed midwives shall continually assess the appropriateness of the planned location of birth, and shall refer to the American College of Nurse-Midwives Clinical Bulletin: Midwifery Provision of Home Birth Services (November 2015), or succeeding document, for guidance, taking into account the health and condition of the mother and baby."* Ms. Struempf stated: certified professional midwives are not certified nurse midwives. We are not bound to their clinical bulletins, just like how we're not bound by ACOG bulletins. We are our own entity, and we practice a different type of midwifery, and we should not be bound to their clinical bulletin. I've said this last meeting, I'm going to say this again, it's not appropriate for a CPM to be bound by the CNM guidelines.

Ms. Struempf moved to draft 3, §16-121-8 Authority for certified professional midwives, subsection (a)(12): *"(a) Licensed midwives practicing as certified professional midwives shall not possess prescriptive authority. Licensed midwives practicing as certified professional midwives shall be authorized to obtain and administer the following non-controlled legend drugs or devices during the practice of midwifery: […] (12) Hormonal implants pursuant to any manufacturer certification requirements, as prescribed by a licensed health care provider with prescriptive authority under this chapter, chapter 453, or section 457-8.6."* Ms. Struempf noted that the same language existed in draft 4, but nobody in this chapter has prescriptive rights. You've given us the ability to have hormonal implants, but you've not given us the authority to use them, so she's confused.

Ms. Struempf then discussed her suggestions to add to the formulary the following things. Silver nitrate: sometimes when babies are born and the umbilical cord is cut, the stump dries and the thing falls away and that makes our belly button. Sometimes the belly button doesn't pull away right and you get a granuloma. Right now, she has to advise her client to pack their child's umbilical stump with salt, table salt like the kind you put on your food, because she doesn't have access to silver nitrate q-tips. They're really simple, you apply them to the stump, and it takes the granuloma away. She is very rural on the big island, a lot of her clients have catchment water, and they live on farms in rural communities, and they get pinworms. If you've never had them, it's really bad. When a woman who is pregnant or her children get pinworms, and she doesn't treat the children but she does treat the moms, and a woman with worms gets malnourished in pregnancy because her body is being taxed by the pregnancy and also by parasites, and the World Health Organization actually says this is on our listed formulary. Magnesium sulfate and calcium gluconate, these are little more controversial, but in rural communities for women who have undiagnosed or late-to-diagnosis – and there again is that word – high blood pressure, pregnancy-induced hypertension, this can save their life. If I'm in a birth and a mom's blood pressure spikes and I'm two hours from a hospital and she starts to have a seizure, I can give her this medication and I can save her life. If it works too well, calcium gluconate is the antidote to bring her blood pressure back up. These work in conjunction and you can't have one without the other. She has talked to the EMS for the State of Hawaii and they do not carry this on their rig. They carry diazepam, which is valium, which is contraindicated to give to a pregnant woman in labor because it can suppress the newborn's respiratory system at birth and actually kill them. It's actually safer if the midwife has access, or we could talk to the EMS and put it on the rigs, but it doesn't help her when she's an hour away from having an ambulance show up, which is a common situation. Promethazine, commonly known as Phenergan, that is an anti-nausea medication. Ondansetron is an anti-nausea medication called Zofran that's given to women in labor. It's also given to women who have hyperemesis gravidarum or who are extremely sick with morning sickness. It's a very common medication and she doesn't have access to it. Metronidazole is for bacterial vaginosis. It's a really common thing that we see with women, especially when they're living off-grid and don't have access to being able to bathe really frequently. Catchment water is one of those situations. Fluconazole is a yeast medication for vaginal yeast infection or haole rot when you get itchy spots. It's a common medication for yeast. Nystatin is for nipple thrush. A really common condition when babies come is the mom's nipples are leaking, the babies are sucking them and they're constantly wet and humid, and it breeds yeast. A lot of new moms in the first eight weeks when they're under her care get thrush of the nipple, and nystatin is the medication for that, and right now she has no access to that. She has to tell them, "try a little apple cider vinegar," or "try a little plain yogurt," and those don't work as well as the medication, so she should have access to that. Progesterone is something that can be used to help a mom

not lose a pregnancy. Some people, she for instance had five miscarriages before she had her first baby when they figured out her body doesn't make enough progesterone to stay pregnant. All she needed was a little supplemental progesterone for the first ten weeks. Estetrol and testosterone, again, she is able to do pre-conception counseling, and in pre-conception counseling we check hormones. She has the ability and knowledge and training to balance someone's hormones, but is not allowed to use the hormones to balance them, so she has to go, "you get diascorea from wild Mexican yam, and you get…" and everyone says, "midwives, they're all hippie-dippie and they're all using plants and herbs," because we don't have any other choices, we've had our hands tied. We have to use the apple cider vinegar and the plain yogurt because we don't have prescriptive rights, we don't have access to the medications we need, so that's her argument for having those on our scope.

Ms. Pinto said, as Ms. Struempf was going through every single ailment that she was plagued with as a rural person, from the umbilical cord to the worms in the stomach to the yeast on the nipples, and all the remedies that she is using, in Hawaiian culture, all of those ones are ones that are listed in Hawaiian plant medicine. So again, she wanted to say that Hawaiian culture and Hawaiian medicine would be really useful in everything that Ms. Struempf just said, of all the things she needs. She can't even get her medications as a clinical midwife, and she can't even get them in Hawaii from Hawaiian education and Hawaiian medicine. So these things that Ms. Struempf had gone through, and also Ms. Pinto described that she is illegal as a Hawaiian practitioner in Hawaii, it's brought up a lot of historical, cultural trauma, and so she is curious if anybody in this Committee is capable to have the skillset to address this trauma that she has experienced from this process of licensure that is six generations old in her family. Is there anyone that has the skillsets that is able to address any of this? Ms. Pinto asked Ms. Minton, do you have any of that? Because as a nurse midwife, your Board of Health has actually acknowledged systemic racism about how the dramatic effects of it is actually the most harm that can go through. As a nurse midwife, they've actually acknowledged that the level of – she is on one of the nurse midwives where they have the Truth and Reconciliation Resolution from the American College of Nurse-Midwifery, where they state, *"Systemic racism is among the greatest long-term threats to our nation, the profession of midwifery, and the people we serve. For ACNM to be an organization to which everyone can feel they belong and can thrive, the BOD and our organization must hold ourselves accountable for our contributions to systemic racism. Speaking the truth on our history and the harm caused by it through ACNM's denial, gaslighting, censorship, and exclusion is the first step in long-overdue restorative measures for our community of Black, Indigenous, and people of color (BIPOC), allowing us to promote inclusion, belonging, and a safe space for all midwives."* Ms. Pinto asked Ms. Minton, as a nurse midwife, that this is actually your board of health, do you have any skills to address this that is coming from your training? In closing, Ms. Pinto noted that as an illegal Hawaiian in Hawaii, all of her training actually has

that, and because she is a Hawaiian health professional, she does have the skillsets to acknowledge of all of this trauma that has happened, for not only herself, but for her community, and that is the number one thing that she actually works with, is the amount of trauma that is inflicted on these processes, and the people that are involved with it, that are on her community.

Ms. Struempf directed the Committee to draft 4, §16-121-10, subsection (a)(1): *"§16-121-10 Grounds for refusal to renew, reinstate or restore a license and for revocations, suspension, denial, or condition of a license; proceedings; hearings. (a) In addition to any other actions authorized by law, the director shall have the power to deny, revoke, limit, or suspend any license to practice midwifery as a licensed midwife applied for or issued by the department in accordance with this chapter, and to fine or to otherwise discipline a licensee for any cause authorized by law, including but not limited to the following: (1) Gross immorality; […]"* Ms. Struempf said, you can't just say "gross immorality." She asked, whose morals are we talking about? Are we talking about the fundamentalist Christians? Are we talking about the Amish? Are we talking about the agnostics? Based on whose morals? "Gross immorality" is not acceptable in this day and age because we can't define that.

Lastly, Ms. Struempf said she would like to see the "parent's rights" provision put back into draft 4.

Ms. Pinto noted that Governor Josh Green made Hawaii a trauma-informed care, and so this is really great example of where that would be really helpful if there was people that were qualified, especially in the Hawaiian community, that were in the room that have this training to offer people. Her thanks to Governor Josh Green for making us a trauma-informed state.

EO Teshima said that she would try to address some of Ms. Struempf's comments. Referring to "diagnostic" being removed from the rules, she referred to the "midwifery" scope of practice as defined in HRS 457J-2: *"'Midwifery' means the provision of one or more of the following services: (1) Assessment, monitoring, and care during pregnancy, labor, childbirth, postpartum and interconception periods, and for newborns, including ordering and interpreting screenings and diagnostic tests, and carrying out appropriate emergency measures when necessary; (2) Supervising the conduct of labor and childbirth; and (3) Provision of advice and information regarding the progress of childbirth and care for newborns and infants."* EO Teshima acknowledged the appearance of "diagnostic tests" in this language and said she would consult with the AG to see if we could put that into the rules based on this definition.

DAG Wong said she understands the references to 457J-2, and she reads that as "ordering and interpreting screenings and diagnostic tests." For context and background, "diagnosis" and the verb "diagnosing" is a term of art used by

physicians, so that is in their HRS chapter. Even nurses, for example, are not allowed to "diagnose" or make a "diagnosis." She understands that midwives can order and interpret diagnostic tests, that's in your HRS chapter, and she is fine with them interpreting diagnostic tests, but she does have a problem with inserting in the HAR "making a diagnosis" or "to diagnose." Those are terms of art, and so if we can stick with the HRS 457-2, "interpreting diagnostic tests," you're fine. With regards to supervision, that's subsection (2) in the definition of "midwifery" under 457J-2, "supervising the conduct of labor and childbirth." She does not interpret that to mean supervising other third-party, unlicensed personnel. She believes that refers to conduct of labor and childbirth, which happens between mom and the midwife. She does not think that unlicensed personnel are authorized to practice under 457J-2.

Ms. Struempf said, it's not safer for a midwife to work alone. We need an assistant. We need help. We need a second pair of hands. We need somebody to work with us.

DAG Wong said, that may be the practical, what happens in reality, but she's sorry for just reading the four corners of HRS 457J. It has no reference to "assistant" or other support personnel. She understands we're in a difficult spot, because DCCA and her department are just trying to follow what the Legislature passed. Ms. Struempf said, but you're not supposed to limit our ability to practice to the full extent of our scope. DAG Wong said, the scope is defined by the Legislature in 457J. Ms. Struempf said, they didn't know what we do when they defined our scope. DAG Wong said, that may well have been the case, and she appreciates the efforts over the past several years to try and fix that, but we can't fix it through rules. Rules cannot exceed what exists currently in HRS. She knows what the realities are, and she doesn't know what to say except that we cannot exceed what currently exists in the HRS, even if the Legislature doesn't know and doesn't fix what you actually do.

EO Teshima asked Ms. Struempf, do you currently use any assistants at all? Ms. Struempf said yes, every birth. EO Teshima asked, then why do you need clarification in the rules if you already use them? Ms. Struempf said, because the Attorney General has ruled that doulas, lactation consultants, grandmothers, everybody are illegal to help at a birth. So now, all the people that she has relied on to be her assistant are now illegal to help her. EO Teshima said, when you say "help you," "assistant," they're not actually involved in catching the baby or anything like that? How are they assisting you? Ms. Struempf said well, they hold the head, they fill the tub, they fill the water, they grab my stuff, they hand me my doppler. EO Teshima asked, is that a doula's job? Ms. Struempf said no, that's an assistant's job. But her students work as doulas. Jobs overlap, it's sort of a complicated question and answer. EO Teshima said, with the previous definition that was in there, they could not practice midwifery. Ms. Struempf said, they're doing what I tell them. EO Teshima said, they're assisting you, but they're not

practicing midwifery. Ms. Struempf said no they're not, they're just assisting me. She needs someone that can just assist me. EO Teshima asked, what do you need that clarified in the rules for if you're already using? Ms. Struempf said, because as of July 1, nobody is willing to help me because they're all scared that they'll be prosecuted by the State for practicing midwifery. EO Teshima said, you just told me they're not practicing midwifery. Ms. Struempf said, but a doula isn't practicing midwifery but the Attorney General says they are. A lactation consultant certainly isn't practicing midwifery but the Attorney General has said they are. EO Teshima said, it came out after the Attorney General did review, that's how the law was written. At that time, everybody went with that. Ms. Struempf said, how do we fix it?

DAG Wong said, she thinks EO Teshima was walking through what exactly your assistants are doing, and if they're not doing the activities in subsections (1), (2), and (3) of 457J-2, then they're not practicing midwifery. The advice letter was very clear on that. It's the activities in 457J-2, subsections (1), (2), and (3) in the definition of "midwifery." With regards to aunties and grandma or whoever might be helping, that was the impetus for the addition of the change in the midwife definition in the HAR. It's trying to lower the temperature to give some assurance to those aunties, uncles, and grandmas who are only giving casual, informal, social, isolated advice. We already have the affirmative activities of "midwifery" in HRS 457J-2 subsections (1), (2), and (3), and we're trying to assist or calm the waters of informal, social, casual advice in the negative for the definition of "midwifery" in HAR. We're trying to help.

EO Teshima said to Ms. Struempf, you also had an issue with the current definition of the HAR saying it doesn't mean anything. This clarifies what midwifery is not. Ms. Struempf replied, that definition of midwifery has to go. You have to try again. EO Teshima said, because now, this applies to your hanai family or your grandmother or somebody who will maybe give advice. Right now, under your current definition of midwifery, that might constitute unlicensed midwife practice. This is meant to address those situations so that they would hopefully not be prosecuted as an unlicensed midwife. That is the purpose of this section. You have what midwifery is in HRS 457J, and you have this definition in HAR which is what midwifery is not, to address those people who may be just giving advice to someone they know that is pregnant, like "hey, drink some ginger tea."

Ms. Struempf said to DAG Wong, under HRS 457J's definition of midwifery subsection (1), *"'Midwifery' means the provision of one or more of the following services: (1) Assessment, monitoring, and care during pregnancy, labor, childbirth, postpartum and interconception periods, and for newborns, including ordering and interpreting screenings and diagnostic tests, and carrying out appropriate emergency measures when necessary[.]"* Ms. Struempf said, "care during pregnancy" is given by doulas, "care for newborns" is given by lactation consultants, "care during the postpartum period" is also given by postpartum

doulas, and "care during labor" can be given by many different people. That doesn't include assessment and monitoring, but she thinks the problem with the definition of midwifery is the word "care," not the rest of it, and she appreciates that EO Teshima is trying to define what midwifery isn't but that's not how you define a word, by what it isn't. She will not vote for that definition, because a definition isn't what it isn't, it's what it is. She's not trying to be difficult, she really loved draft 3 and was so disappointed by draft 4.

Ms. Duarte's comments

Beginning with the "midwifery" definition in draft 4, Ms. Duarte said she would also have to vote "no" against this definition compared to draft 3. Based on her understanding of things that have been said previously, we cannot just narrow this definition of midwifery. An email on draft 3 said that unfortunately, we cannot add in any more exemptions. Although this is not an exclusion, it still is exempting certain types of interactions and things that are associated with the activity that is defined in midwifery, HRS 457J-2, as just being unfortunately a blanket statement of what needs a license or an exemption for. At our last meeting, it was discussed that all created rules must adhere to the underlying law, HRS 457J. Admin rules can be used to clarify the statute, but the rules cannot create anything new that doesn't already exist in the statute.

She knows the community has not had access to this, and she was going over past meetings, and when DAG Wong was going over the sunshine law, and last night she realized that they're supposed to have access, if it's all of the board packet she doesn't know, but the public should have access to come somewhere to see these documents, even if it's not posted online. She's curious if we are covered by the sunshine law because it says in here, but she doesn't know because these are interim rules, so there may be rules that we don't have to adhere to. She just wanted to make note of that because they don't have access to the draft, that definition of "midwifery" in draft 4 is: *"Midwifery" means providing care to women and infants that does not include and that goes beyond mere casual, informal, social or isolated interactions such as when family members provide support and assistance; no compensation or consideration is received; there is an absence of a formal professional-client relationship; minimal or incidental levels of midwifery care are provided; and there are no verbal or written representations about professional qualifications, skills, experience, credentials, licenses or certifications."* In draft 3, the definition of midwifery was: *"'Midwifery' means providing primary health and/or maternity care to women and infants."* She thinks that came from SB 1033, and now we have a new one. To her, this is not clarifying midwifery, it is creating something new, because this stuff could have and should have been put in the exemptions. A lot should have been put in the exemptions, but this stuff specifically. The HRS 457J is what gives DCCA statutory authority to regulate midwifery, and we or they cannot define midwifery in a way that conflicts with HRS 457J and takes precedence over these rules. She

wanted to point out and go piece by piece. The language *"that does not include and that goes beyond mere casual, informal, social or isolated interactions"* is not in the exemptions category that exempt people from having a midwifery license. That would've been good and common sense, but it's not in there, and it should be in the statute, not in the rules. Where it says *"when family members provide support and assistance,"* family members are not included in the statute so providing any activities other than the definition would be considered, unfortunately, practicing midwifery without a license. This is mentioned in the AG letter in 2a and 2b. There is only a specified group of family, specifically named, that can provide that type of care, and the AG letter did say that extended family unfortunately is not recognized as those permitted to assist in care. Moving on to *"no compensation or consideration is received,"* as Ms. Struempf pointed out, draft 3 which was a great draft stated that part of the practice of midwifery was regardless of compensation. Now, all of a sudden, it's the opposite – no compensation or consideration is received. This should have been in the exemptions, but it's not, and the AG letter is clear on this factor that it's the activity, unfortunately, that defines whether you are practicing midwifery or not. In the AG letter it says, "regardless of whether money is exchanged, they are practicing midwifery without a license" in 2a. The next part is *"there is an absence of a formal professional-client relationship."* HRS 457J-6 only exempts professionals who are *"[l]icensed and performing work within the scope of practice or duties of the person's profession that overlaps with the practice of midwifery."* This just should have been put in the exemptions, not in the rules. There's no statutory authority. Then to say in the proposed rules that "*minimal or incidental levels of midwifery care are provided,"* to her that's very confusing to say that there's a specific level of midwifery that you can practice to not be practicing midwifery, and she doesn't think it has statutory authority. Lastly, *"and there are no verbal or written representations about professional qualifications, skills, experience, credentials, licenses or certifications,"* this should have been put in the exemptions, but it's not. This midwifery definition, she doesn't know how to amend this draft in a Committee-like, but she would have to vote "no" on this definition and adhere to the definition in draft 3.

She has one more comment since Ms. Struempf hit a lot of stuff earlier, she asks, why did we take out the parental rights? That was in draft 3, *"nothing in this chapter abridges, limits, or changes in any way the right of their parents to deliver their baby where, when, how, and with whom they choose, regardless of licensure under this chapter,"* and she wants to know why this was taken out of draft 4. EO Teshima said, for the same reason you guys are opposed to this definition of midwifery – that it creates an exemption. Ms. Duarte said, OK. Lastly, she wanted to close with her earlier statement about the sunshine law and making documents that are not stamped like DAG Wong was saying unless they're stamped confidential, allowing them to be accessible even if people have to park here and go into your office two days before to get it, so that they're able to testify on this and be a part of this process before the public hearing.

Ms. Herrelson's comments

Ms. Herrelson echoed what the other two Committee members have said about the definition of midwifery, specifically the language *"minimal or incidental levels of midwifery care are provided,"* what is a minimal level of care that is exempt? Is it catching one baby, is it a prenatal visit? She agrees that this isn't the definition of what midwifery is. Secondly, she circled back to the diagnosis conversation, and wanted to challenge DAG Wong about whether they are allowed to diagnose. She understands that nurses don't make a diagnosis, but that's because they're not autonomous providers. Meanwhile, LMs are autonomous providers meaning we don't have physician oversight, we don't work under another provider. Same for CMs with a bigger scope of practice. She clarifies that she does think they have capacity to make a diagnosis, and echoes the ACNM bulletin on the Midwifery Provision of Home Birth Services, LMs don't work under ACNM or answer to them.

Also, back to the formulary, mag sulfate is a lifesaving medication. Anyone doing rural maternal healthcare should have access to it. Nitrous oxide is a very high-benefit medication with very low risk in an out-of-hospital setting. Her last concern is the section we've taken out the ability for licensed midwives to have employees, support personnel, or students who aren't enrolled in a MEAC program. That's a big concern for her because all of her assistants are not licensed, and it's very difficult in a rural healthcare setting to get several licensed midwives at one birth, and we all need support. She's experiencing the same thing that Ms. Struempf is experiencing where she doesn't have people who are willing to assist her at births right now because they're fearful. EO Teshima asked, what do your assistants used to do? Ms. Herrelson replied, similar things to what Ms. Struempf said, setup, breakdown, might have them check a blood pressure, listen to fetal heart tones, charting, neonatal resuscitation and CPR. In emergencies, they would definitely be providing hands-on healthcare.

Ms. Hatcher's comments

Ms. Hatcher's only comment was that the definition of "midwifery" in 457J-2. She believes that it is clear that this does protect non-midwives because the word is "and" in *"'Midwifery' means the provision of one or more of the following services: (1) Assessment, monitoring,* ***and*** *care during pregnancy, labor, childbirth, postpartum and interconception periods, and for newborns, including ordering and interpreting screenings and diagnostic tests, and carrying out appropriate emergency measures when necessary[.]"* Ms. Hatcher said, it's all-inclusive. It doesn't say "and/or." So just offering care during pregnancy is not part of the definition of midwifery. That's how she reads the English language in that sentence. Also, "diagnostic" is mentioned right in that definition, and she agrees that making a diagnosis is going to put midwives in jeopardy of practicing medicine without a medical license, so she's also okay with that definition. As far as the

definitions in draft 4, under "midwifery," at first she agreed that that was a very complicated and hard-to-understand sentence, but as she looked at it more and more, she sees it as protecting non-midwives who are attending births. She totally agrees that where it says *"minimal or incidental levels of midwifery care"* is very dangerous to say that, because that's saying right there that those are levels of midwifery care, and so we have to use another defining term. She agrees that that is very scary for people attending births, thinking, "oh, am I crossing a line, that now am I'm providing an incidental or minimal level of midwifery care?" She does feel that that definition in general does protect non-midwives. She feels that by omitting birth assistants from this draft, it protects midwives from being accused of supervising people at the birth who are loosely associated, like friends and family at the birth who are helping. We all know that this happens all the time. There's a sister or cousin who's interested in midwifery and they want to be at the birth and they want to help, but if you put the midwife in charge of supervising, if according to the law anyone at the birth the midwife is supervising them, that is very precarious for who all the midwife is supervising. She just thinks that the misunderstanding of the law has created the fear of prosecution for non-midwives, and she thinks that's partly what's driving the lack of ability to find birth assistants.

Ms. Pinto's comments

Ms. Pinto had two points. One, in the definition of "midwifery" we were just talking about, it's not "and/or," but it's underlined that it's the provision of "one or more," per the language of HRS 457J-2: *"'Midwifery' means the provision of **one or more** of the following services: (1) Assessment, monitoring, and care during pregnancy, labor, childbirth, postpartum and interconception periods, and for newborns, including ordering and interpreting screenings and diagnostic tests, and carrying out appropriate emergency measures when necessary[.]"*

Ms. Pinto asked DAG Wong, in a town hall meeting, Speaker Saiki on February 21st said, briefly paraphrasing, "the AG letter is just an opinion." Is that common, for a legislator to discredit the AG letter? From her understanding, she thought the job of the Attorney General was to interpret the law, and that's what helps legislators inform their decision around the law.

DAG Wong replied, that is correct, but the full backstory is that there's many different levels of "opinions" and "advice" and it can vary from verbal to written advice. Verbal advice, for example, is what we give at board meetings. It can be a telephone call. Written advice is what the letter was, and she cannot speculate what Speaker Saiki meant by his terms, but it is not a full legal published opinion. There are many different grades of opinion and advice, and he was, she thinks, making the distinction that it's not a full, published legal opinion that is afforded recognition by circuit courts, for example. It's just a written advice letter.

DAG Wong wanted to go back to the prior Committee member's comment about the HAR definition of midwifery. Perhaps it would be better if "minimal or incidental levels of care" was deleted? Would that help the definition? She understands that you want to be affirmative in the definition of midwife activities, and that's what HRS 457J-2 affords in listing those particular activities, as Ms. Hatcher was saying, that she understands why we were trying to calm some waters by saying what it's not. It's not that the family members are now given free reign to do anything, it's still tied to the activity, and if it's mere social, casual, informal, or isolated incidences, then family members would not be considered engaged in the practice of midwifery. She was trying to think of an example of how you define something in the negative, and the only thing she could think of was when you say "black is black," that would be the affirmative, like "the darkest of all colors," and the negative would be "the absence of all color, the absence of ROYGBV." So those definitions can work to complement each other, and we're trying to help to lower the temperatures, so isolated, casual, social incidences are not considered engaged in the practice of midwifery, even by family members. And you can't insert new exemptions into HRS 457J-6. Only the Legislature can do that. So we're trying to do the best that we can, and this is complementing HRS 457J-6 and 457J-2 without exceeding the scope of anything in 457J-2.

Ms. Duarte said, the issue is the exemption under HRS 457J-6(c): *"(c) Nothing in this chapter shall prohibit a person from administering care to a person's spouse, domestic partner, parent, sibling, or child."* Ms. Duarte said, it's pretty narrow right there who can administer within the family that type of care. That's why she feels uncomfortable with the midwifery definition.

Ms. Minton's comments

Ms. Minton directed the Committee to draft 4, §16-121-4, Renewal; restoration of license, subsection (b): *"Failure to renew a license shall result in forfeiture of that license. Forfeited licenses may be restored within one year of the forfeiture date upon payment of renewal and restoration fees. […]"* She suggested to include "upon submission of a complete renewal application," because she thinks they have to do an application when they renew.

One of her recommendations for change in language, under §16-121-5, subsection (a), and it is used in at least one other place where they have the language of "female reproductive systems," she says that the language has evolved over time and we now use the language of "assigned female at birth."

In that same section, under subsubsection (b)(2): *"(b) Practice as a certified midwife means the full scope of midwifery, that incorporates caring for all clients in all settings and is guided by the scope of practice authorized by this chapter, including but not limited to: […] (2) The Standards of Practice of the American College of Nurse-Midwives and American Midwifery Certification Board, or*

successor organizations; provided that the American College of Nurse-Midwives shall have no legal authority over the director and shall have no legal authority or powers of oversight of the director in the exercise of the director's powers and duties authorized by law." EO Teshima had asked, "is this necessary to refer to another standard of practice?" Ms. Minton's response was yes. The standards of practice for certified midwives and certified professional midwives are quite different, and the ACNM nationally defines the standards of practice for all certified midwives, so it gives guidance on what a certified midwife is trained to do, and naming it here removes the need to list out all of the specific practices that a certified midwife can and can't do. It essentially gives the midwife program documents to reference should someone file a complaint, and it gives a certified midwife a document to look to when they're wondering if something is within their scope of practice. Obviously they would still need to come to the Director if they had a question about that, but in general, that would be Ms. Minton's recommendation. She understands that there's a difference between what a national professional organization's standards and scope are versus what a state may give. A state is not required to give full scope practice of professionals. That is defined by what the legislators write into law. At the same time, within the scope that is provided within the State, that in general I do think looking to the standards for that profession is important.

Further in that same section, subsection (d)(4), *"Ordering, interpreting, and performing, screening, and therapeutic examinations, tests and procedures,"* EO Teshima had asked, "taught in midwifery school?" Ms. Minton said that certified midwives and certified professional midwives are taught newborn metabolic screening and can also perform newborn hearing screening as examples. She thinks the word "and" could be replaced with "and/or," and she had offered suggestions on how to change it: "Ordering, interpreting, and/or performing screening and therapeutic examinations, tests and procedures," but she may be misreading the sentence a little bit.

Moving further down to subsection (d)(7), *"Serving as a consultant and resource of advanced clinical knowledge and skills to those involved directly or indirectly in client care,"* she recommended removing the word "advanced" and using the word "midwifery" because she doesn't know what "advanced clinical knowledge" specifically means in relation to the midwife, especially in relation to who they may be consulting.

Moving further down to subsection (e), *"A licensed midwife shall comply with the requirements of this chapter; participate in data collection and peer review requirements adopted by the department; recognize limits of the licensed midwife's knowledge and experience and plan for the management of situations that exceed the scope of authorized practice; and consult with or refer clients to other health care providers, as appropriate."* She wanted to clarify if the Department is just referring to what may be listed directly in the admin rules and

the statute, and she means that in the sense because certified professional midwives define their own individual scope of practice, bringing it back to a conversation from before about other states have like 30 pages of admin rules to list what can and cannot be done, that does tie back to actually the next paragraph in §16-121-6, Care provided by licensed midwives; requirements, where it does refer to the American College of Nurse-Midwives Clinical Bulletin: Midwifery Provision of Home Birth Services that at least there's guidance in there, so she was having some questions around how that would really be interpreted. She wanted to comment that the North American Registry of Midwives, NARM, that certifies CPMs, they don't have specific bulletins to define conditions and levels of care specifically and how to manage that, and the NACPM as well, so she wanted to comment it's been stated that certified professional midwives don't abide by ACNM bulletins and they don't abide by ACOG bulletins. She would share that, for example, the definition of pregnancy-induced hypertension is defined within an ACOG bulletin on how to manage that. So if a CPM chose to define that very differently, and to manage that very differently because they actually have no documents that tell them how to do that, she does believe that would still be considered practicing outside of the standard of care related to obstetrics. She believes we all use different entities' definitions if our professional organization does not define that specifically when we're talking about an area where we work in, such as obstetrics and midwifery. That bulletin specifically does lay out different levels of care related to conditions that someone may have, and that provides guidance to what would be considered a standard of care.

Moving further down to §16-121-8, Authority to purchase and administer certain legend drugs and devices, around these additional drugs that are listed, Ms. Minton knows it's shorter here because the other ones are listed in the statute, so she does understand that. She wanted to share that nitrous oxide is used for pain management and non-hormonal contraceptives are things that are within training by certified midwives and certified professional midwives. A hormonal implant, of course it's not named but currently that would be Nexplanon, and that does require certification by the manufacturer to be able to place it and remove it by any licensed provider. Just because she's an APRN does not mean she can do that, she does need to be certified by the manufacturer. This essentially, in order to help increase access to family planning choices for clients, the idea is that, because currently a certified midwife and certified professional midwife do not have prescriptive authority, that if they did have that certification and a licensed professional such as an APRN or a physician or a physician assistant ordered the device, then it would be acceptable for the trained, licensed midwife to place or remove it. She is comfortable with that.

Moving further down to §16-121-9, Unprofessional conduct; types of unprofessional conduct, Ms. Minton notes that there appears to be an absence of something along the lines of failing to properly document all care provided to a client, which she believes is critical, and that is a concern. In subsection (6)(G),

"(6) Performing unsafe client care or failing to conform to professional standards required of a midwife which poses a danger to the welfare of a client including: […] (G) Leaving a midwifery assignment or abandoning a client without properly notifying appropriate personnel; […]" Ms. Minton said that this goes back to, what does a licensed midwife do if a client declines transfer to another provider? Are they considered "abandoning a client"?

Ms. Minton said she had accidentally skipped one of her prior comments, which was related to this topic. Returning to §16-121-6, Care provided by licensed midwives; requirements, draft 3 included a subsection (e) which was deleted in draft 4. That subsection in draft 3 read: *"(e) If the mother or baby's guardian refuses assistance from appropriate licensed health care providers or the 911 emergency system, the licensed midwife shall continually urge the mother or baby's guardian to transfer care to an appropriate licensed health care provider and may continue to provide care to save a life; provided that the licensed midwife shall only perform actions within the licensed midwife's technical ability."* Ms. Minton thinks this subsection (e) is important because it addresses what the licensed midwife should do when a client declines services during potentially life-threatening situations or conditions beyond what a midwife is trained in. She does not say "outside of their scope" because we do not define what client conditions are outside the scope of a licensed midwife. Within that, she wanted to think a bit more. She's not certain all the language in subsection (e) is needed to put back in, but just wanted to think a little more about how to ensure that it's clear because when we're working in the community, if somebody does have a life-threatening condition that arises, and it's very clear that we're supposed to activate the 911 system, and it is the client's right to decline it when it comes, that puts the provider in a situation. What are we doing at that time? They're not in a hospital, and they do have a right to decline services, they have a right to choose to say that they're comfortable if they or their baby dies. She's never taken clients that, during initial interview, would say that they'd refuse transfer because she doesn't personally need to be at a birth where she's just witnessing something that she cannot facilitate improvement in the situation, that's the personal choice. When we're saying leaving a midwifery assignment or abandoning a client without appropriately notifying personnel, then the question is, as long as they've activated 911, if the client refuses, then does that protect the midwife? Just wanted to get more clear on that.

Ms. Minton does recognize what DAG Wong was saying, which is that we can only work with what the statute affords us, and that doesn't include full-scope midwifery since we've known since it was enacted in law because it very much limits certified midwives and is unclear for certain things for certified professional midwives. When she read the definition of midwifery in the rules, she understood that it was trying to work with the, for lack of a better word, unclean definition for midwifery in the statute. She recognizes that these are interim rules, only in effect for one year, and that does not mean that moving forward this definition cannot be changed. So

she is comfortable with what is here, and also agrees with maybe reworking a little bit that term *"minimal or incidental levels of midwifery care,"* provided that she doesn't know if the concept is to put pregnancy, postpartum, and newborn care rather than specifically stating midwifery care. That may be more protective for doulas and lactation consultants if we just name the type of care rather than naming it "midwifery" so that's a suggestion.

Ms. Struempf said, hormonal implants include hormonal IUDs. Nexplanon may be one thing that could be excluded, but it also could be something that the manufacturer could certify the certified professional midwife to implant. But IUDs come in both non-hormonal and hormonal forms, they are considered a hormonal implant, so she believes that should still fall under the CPM. Circling back to §16-121-9, Unprofessional conduct; types of unprofessional conduct, subsection (6)(G), *"(6) Performing unsafe client care or failing to conform to professional standards required of a midwife which poses a danger to the welfare of a client including: […] (G) Leaving a midwifery assignment or abandoning a client without properly notifying appropriate personnel; […]"*, Ms. Struempf said she's always wondered who "personnel" is because they're all independent providers, so she doesn't know who that is. Is it the hospital or 911 system? She thought it was nebulous and could be better defined.

Ms. Struempf was also unclear about what Ms. Minton was saying about §16-121-5, Scope of practice. Ms. Struempf cited subsection (c): *"(c) Practice as a certified professional midwife means the full scope of midwifery that incorporates caring for all clients in all settings and is guided by the scope of practice authorized by this chapter, including but not limited to: (1) Advanced assessment, selection and administration of therapeutic measures pursuant to section 457J-11 and within the certified professional midwife's education, certification and role; and (2) The Job Analysis and the Comprehensive Skills, Knowledge and Abilities Essential for the Competent Midwifery Practice defined by the North American Registry of Midwives, or successor organization, provided that the North American Registry of Midwives shall have no legal authority over the director and shall have no legal authority or powers of oversight of the director in the exercise of the director's powers and duties authorized by law."* Ms. Struempf asked for clarification on what Ms. Minton was talking about regarding this section.

Ms. Minton said she didn't address the CPMs, she was addressing it within the CMs. Ms. Struempf said perfect, thank you, that's all that matters. Ms. Minton said, since you mentioned something about hormonal implants, that reminded her of the last thing she was going to comment on. She clarified two things: one, a hormonal implant is not an IUD. An intrauterine device is not an implant. An implant is specifically talking about something we're placing in their arm. It's a different language when we're talking about IUDs. Also, she wanted to clarify, since Ms. Struempf talked about expedited partner therapy, that actually is a very defined term and practice and that is us prescribing medication to a partner when

we're talking about STDs, so just wanted to clarify that. Her comment was around Ms. Struempf's recommendations for adding additional medications to §16-121-8, Authority to purchase and administer certain legend drugs and devices. Ms. Minton generally does not recommend specifically labeling names of medications. She understands nitrous oxide is here, but for other medications Ms. Struempf is recommending, Ms. Minton instead suggests that we discuss classes of medications because otherwise the admin rules need to be changed over time as medications update, especially with things that may have resistance, etc. She doesn't agree that testosterone and estradiol and progesterone are specifically in the purview of certified professional midwives. Testosterone is a controlled substance and requires a DEA license, and certified professional midwives do not specifically have advanced pharmacology training, and that's why we don't recommend prescriptive authority for certified professional midwives. Progesterone is not in general recommended for use during pregnancy with people with history of pre-term births. That has definitely actually inclusive of some of those forms being pulled off of shelves through FDA. She does not agree with those recommendations, but does agree further with discussing any potential classes that, in her understanding, specifically can be purchased by the midwife and administered by the midwife. The difference in prescriptive authority is that you are essentially prescribing a medication for a person to be self-administering at home or elsewhere, that you are not managing.

Ms. Struempf, when I can't prescribe it, they have to pay for it out-of-pocket and we can't bill their insurance. Her daughter just got an IUD and it was an implant and she had to sign for her because she was under 18 because it was an implanted device. You can get birth control at the age of 14, but it was considered an implant, so she had to sign for it. She just went through this.

Public testimony: Laulani Teale

Laulani Teale raised her hand and was promoted to panelist.

Ms. Teale was very concerned about the process. First of all, it's not legal according to HRS 92-7.5. It's really important that all drafts need to be given to the public 48 hours in advance. She knows everyone's overworked, but she's going to be a real stickler and she hopes the OIP doesn't have to get involved. We can't have a really good discussion here without that in front of us also. Also, the source is a little bit unclear. The Committee is supposed to represent the collective expertise so not sure why they didn't actually compose the rules. It should be started over properly and fairly using correct sources and objective criteria. Some of the references were incorrect, especially because nurse-midwives keep being mentioned, rules according to CNMs, and not sure why that keeps coming up because we're talking about CPMs which is an entirely different practice. The rules themselves are not OK, they're overly restrictive, oppressive, dangerous, and unnecessary, and they confer an enormous administrative burden

in their enforcement, especially as there is bound to be conflict. Someone could really be harmed by trying to comply with these rules and that in turn confers liability onto this body and others. There really needs to be outside legal review of these rules, especially in light of the recent lawsuit, Kaho'ohanohano, et al. v. State of Hawaii, et al. that was filed last week. It's clear that HRS 457J as a whole is not in compliance with state laws, that state laws are disagreeing with each other. So this really needs to be vetted by outside legal review to ensure that this body is not subject to liability or shame. There is historic context here, and that is important too, that increasingly restrict rules are the way that midwives were erased with the first licensure program in 1931, and they literally regulated midwives out of existence by increasingly strict rules. She has a lot more to say, but we can discuss better if these things are simply distributed to us.

Public testimony: Rebekah Botello

Rebekah Botello raised her hand and was promoted to panelist. She stated that she has been on from the beginning, been largely part of this defense of midwifery issue since 2019. She is a 24-year veteran doula, a childbirth educator, and she teaches up to 400 people per year for free for the last 20 years in our community, just how to have better births wherever they choose to be. She's a pastor, and while she rarely discusses any religious rights, she wanted to state that midwifery is part of people's faith, it's a part of her faith, and the DCCA, the governor, the Attorney General's office, legislators, she feels would be wise to address the targeting of religious freedoms by addressing HRS 457J and maybe even to put a moratorium on the statue until the law can be amended. She also recognizes that all of the discussion today has been on draft 4, and as Ms. Teale stated, because the public did not have the ability to review draft 4 at least 48 hours prior to the Committee meeting, she was wondering if the discussion of everything on draft 4 is a violation of the Sunshine Law.

She is also aware that there is a lawsuit in regards to the midwifery restriction law, HRS 457J, that was filed on February 27th, and if the DCCA is under the auspices of the governor's offices, which is her understanding, she is asking if the DCDA and this Committee advocate with the governor's office to issue a moratorium until the lawsuit is settled.

Finally, Ms. Botello was a person at the town hall meeting asking questions of Speaker Saiki personally. If she is understanding what DAG Wong is saying, the letter that Speaker Saiki was referencing is not a formal letter. She doesn't understand what a "formal" letter is. She does have a video clip from that town hall meeting with Speaker Saiki saying the letter is just a letter, it's just an opinion, it didn't have the force of law. As a person largely out of politics, but in the public, and someone says, well, what does that mean to us in the public? What does that mean to me as a doula, as a childbirth educator, as a pastor, as an auntie, what can I do, what can I not do? It seemed like the Attorney General's letter was pretty

clear in the legalities and illegalities and their interpretation of HRS 457J. So I thought the Attorney General's letter was to clarify the law.

Public testimony: Tara Compehos

Tara Compehos raised her hand and was promoted to panelist. She stated she is a licensed midwife, meaning she is one of the people whose practice is being defined by this scope of practice. She had a couple of questions, she doesn't expect them to be answered because of their limited time.

Her first question was that DAG Wong said that HRS 457J defined their scope, but she is fairly certain that it is stated very clearly in that law that it is this Board that defines our scope, so that was confusing to her, she is depending on you folks to define our scope. Her second question was, the midwifery definition that has been discussed today, is a sign of the kind of writing that has been used the entire time. It doesn't make sense, it's too wordy, it's a mess. She respects everybody's efforts that have been made here. She would like to respectfully ask that you guys start over, because you're defining my practice, and the practice of all these other practitioners, almost 40, and all the people we care for, and she is also the mother of a kanaka ʻōiwi young woman who will be giving birth in this State someday, and you're defining what she can have for her care, so she'd really like you to try again. The midwifery definition that was read today makes no sense, it's ridiculous, it's embarrassing, you need to scratch it and start over. And if your dedication to appropriating this word is stronger than making a definition that makes sense, someone else needs to write it. The last thing she would like to ask is, why is the Department trying to make certified professional midwives practice the medical model of care? It is very clear that we practice the midwifery model of care. We are an alternative to the medical model of care, which is why consumers choose us. You need a new scope of practice.

Public testimony: Margaret Ragen

Ms. Ragen raised her hand and was promoted to panelist. She is a licensed midwife that is impacted by these regulations. She has been involved in conversations regarding how to address limitations of Act 33 through implementation of helpful regulations with your advisory board. Therefore, there are four aspects she wants to address. With deep regard and a heart full of tears, she wants to address the document that was stated regarding the Truth and Reconciliation Resolution. She is actively engaged with ACNM on a national level to address what will be our point of action to address wrongdoings that have been done. She is honored to be a part of the conversation moving forward. Regarding definitions, when you involve definitions in rules, you make up for lapses in definitions that were not included in previous acts. There are a number of terms that have not been defined that are being used. I have presented them to the advisory board for consideration and for inclusion. One of the biggest terms in

conversation here was "midwifery," which has already been defined in Act 32. Her suggestion would be to make a very simple definition regarding the provision of care as provided by licensed midwives under this chapter to control its jurisdiction. Regarding scope, one of the main problems with Act 32 is the distinction between CPMs and CMs was not well-established. In the current draft, this again continues. She suggests a sub-chapter for CMs and CPMs that draws clear distinctions between the two. Finally, she would like the ability to participate in the conversation of the audit in this final year before this act sunsets to discuss the impact of 32 on the CM credential. Currently she is the only CM licensed in Hawaii in comparison to 36 CPMs. The reason for this is CMs are not an employable credential by hospitals or clinics. She is currently involved in starting a private practice in order for her ability to practice within the limited scope.

Public testimony: Laura Acasio

Ms. Acasio raised her hand and was promoted to panelist. Ms. Acasio wondered if a formal motion was made and second to continue this meeting. She understands that it was said that we need to finish and go on, but she understands that under formal meeting law for sunshine, it would be continued to another date. She also is very concerned that this Committee is discussing what the Legislature is abdicating in not addressing this over the past several years, as was intended in the original act. Draft 4 was not publicly noticed, as according to the sunshine law, chapter 92. Very concerning. That's another reason for this meeting to be either nullified or redone or extended.

As a doula, and someone who attends birth, her understanding is from the AG letter is this criminalizes her from attending births, and the MAC is discussing something here to make HAR rules that cannot supercede HRS 457J, which the AG has already written that she would be criminalized and others also would be criminalized. She would also like to have inserted into the comments in the record that Governor Green has just released an Executive Order number 24-01, and she would like to know if DCCA, the Director, and/or this Committee is following this executive order. She thinks the document itself should be put in the records. She cited the following provision from the Executive Order:

"NOW, THEREFORE, I, JOSH GREEN, M.D., Governor of the State of Hawaii, pursuant to my authority under the Constitution and laws of the State of Hawaii – including, but not limited to, article V, section 1 of the Hawaii Constitution, and sections 27-62, and 27-63, Hawaii Revised Statutes (HRS) – do hereby DECLARE that all executive state departments collectively move towards becoming a trauma-informed state and do hereby ORDER the following: […]"

Ms. Acasio said the language that follows consists of many orders that departments need to be following. She is concerned that a lot of the discussion is

outside of that, and needs to be brought in line with current Governor's Executive Order around "trauma-informed state."

Lastly, Ms. Acasio asked if the AG could address this issue – in trying to cool the temperature of the discussion, again, this is what the Legislature has been abdicating, and folks have been trying to do for many years, is have this really respectful, robust conversation around the definitions that are quite entangled and very intricate and intimate, based on the fact that we're talking about birth and people's choices. To the DAG and the Committee: does it have the purview to even be discussing HRS, what is defined currently and superseded in HRS?

She would like to close that we do have a current legislative measure that is in Committee, in Finance at the moment, HB 955, that would properly deal with this discussion.

Public testimony: Kiana Rowley

Kiana Rowley raised her hand and was promoted to panelist. First, she was testifying as a community member. The extreme time restrictions of this meeting, given two hours for the importance of decision that's being made, she wanted to comment as a public member who's trying to participate and who's come to every meeting, that it's extremely hard to follow rules when you're listing line numbers, page numbers, nobody's reading the entire comment, and she doesn't have a piece of paper to look at to actually be able to give testimony based on the content of what is being suggested without having access to it, and so she'd like to thank every member who brought up the sunshine law. She's also contacted OIP and requested that for future meetings we have access to the docs so we can give real testimony.

Her second point is that, as a practitioner, she was practicing as a midwife prior to HRS 457J in 2019. Based on the temporary exemption, she enrolled in midwifery school in a CNM program in August 2020. It was supposed to be a 2-year and 4-month program. She is now in 3 years and 7 months, and on Wednesday, she was informed by the faculty leadership that they're recommending that she switch tracks to a women's health NP program because there is no pathway for her in Hawaii without traveling to the continent and leaving her kids. It is impossible for her to move forward as a practitioner and serve her community, who are contacting her, without providers in her community. She has done everything she can. She would request that this board ask for a moratorium to protect her and her sister midwives who are doing everything they can to comply with the law without pathways. This is not enough time. We're not being given the information that we need to participate in the program and in the process.

Next Meeting: TBA

Adjournment: The meeting was adjourned at 11:12 a.m.

Taken by:

/s/ Alexander Pang_____
Alexander Pang
Executive Officer

LAT

3/28/24

[ ] Minutes approved as is.

[ ] Minutes approved with changes; see minutes of _____.