OFFICE OF PROFESSIONAL REGULATION
VERMONT SECRETARY OF STATE

Doula Sunrise Report

Vermont Office of Professional Regulation

January 2025

Executive Summary

The Office of Professional Regulation ("OPR") has found that certification of Community-Based Doulas is necessary to protect the public because consumers of community doula services need to be able to rely on qualified support services during pregnancy, birth, and postpartum. Doulas are trained, non-clinical, non-medical support people who provide emotional, physical, educational, and informational services to birthing individuals before, during, and after childbirth. Community doulas provide doula services to under-resourced and marginalized populations at low- or no-cost, most often through community-based agencies.

Maternal mortality and morbidity in the United States ranks as the highest among developed countries and rose sharply in 2021. Substantially disparate, negative maternal health outcomes are statistically evident for non-Hispanic Black, Native American, and rural birthing persons, as well as those from other marginalized and under-resourced populations, including Medicaid recipients. Doula support throughout pregnancy, birth and postpartum is recognized as an evidence-based intervention that significantly improves maternal health outcomes.

In Act 97 (2024), an Act relating to Medicaid coverage for doula services, the Vermont General Assembly determined it is necessary for the public health, safety, and welfare for the State to regulate the doula profession. The Legislature directed the Vermont Office of Professional Regulation to undertake a Sunrise Review of doulas in accordance with 26 V.S.A. Chapter 57 to determine the appropriate form of regulation for the profession.

OPR has completed the Sunrise Review process in consultation with stakeholders. The Office, with support from stakeholders, has determined Certification of Community-Based Doulas is the appropriate form of regulation, as consumers of doula services may have substantial interest in relying on the qualifications of community-based practitioners. Neither registration nor licensure for all other Vermont doulas would be appropriate to mitigate the harms of disparate rates of maternal mortality and poor health outcomes in underserved, under-resourced, and/or marginalized populations.

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Introduction & Background

A. Role of Doulas in Maternal Support

A doula is a trained, non-clinical, non-medical support person who provides direct emotional, physical, educational, and informational services to birthing persons before, during, and after labor and childbirth.[1] Doulas provide birthing persons continuous companionship and emotional support during labor; information about potential pregnancy, childbirth, and post-partum complications; help with physical positioning and non-medical pain management techniques during labor; facilitation of communication between the birthing person and health care providers; and assistance with advocacy for labor and childbirth health care preferences.[2] Postpartum, doulas continue to provide emotional support, information about topics like breastfeeding, infant care, and coping skills, and may even help prepare a meal to support the family.[3] Traditionally, doula services have required out-of-pocket payment, with no public or private insurance coverage available.[4] Thus, the services have been limited primarily to birthing persons of financial means, and many individuals who have the highest need for support do not have access to services that would lead to better maternal outcomes.

Doula care improves health outcomes and experiences for pregnant individuals. Research has shown that with doula support, birthing persons and their babies have "lower rates of preterm birth, low birth rate, epidural use, and birth complications."[5] Significantly, birthing persons with doula support had 52.9% lower rates of cesarian section delivery and 57.5% lower rates of postpartum depression/anxiety.[6] "Doula care is increasingly recognized

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[1] Zainab Sulaiman, MSc, Vice President of Impact and Advocacy, HealthConnect One Melissa Mullins, MPA, University of California, Berkeley, Goldman School of Public Policy
"Getting Doulas Paid: Advancing Community-Based Doula Models in Medicaid Reimbursement Conversations." Accessed December 2024. https://healthconnectone.org/wp-content/uploads/2023/02/Getting-Doulas-Paid-Advancing-Community-Based-Doula-Models-In-Medicaid-Reimbursement-Conversations.pdf

[2] Safon CB, McCloskey L, Estela MG, Gordon SH, Cole MB, Clark J. Access to perinatal doula services in Medicaid: a case analysis of 2 states. Health Aff Sch. 2024 Mar 4;2(3):qxae023. doi: 10.1093/haschl/qxae023. PMID: 38756922; PMCID: PMC10986220. https://pubmed.ncbi.nlm.nih.gov/38756922/

[3] Id.

[4] Marshall, C., Nguyen, A., Yang, C., Gómez, A.M. (2023). Understanding Barriers and Facilitators to Payer Investment in Doula Care in California. Berkeley, CA: University of California, Berkeley https://share.berkeley.edu/wp-content/uploads/2024/08/Understanding-Barriers-and-Facilitators-to-Payer-Investment-in-Doula-Care_brief.pdf

[5] Arcara J, Cuentos A, Abdallah O, et al. What, when, and how long? Doula time use in a community doula program in San Francisco, California. Women's Health. 2023;19. doi:10.1177/17455057231155302 https://journals.sagepub.com/doi/10.1177/17455057231155302

[6] Falconi AM, Bromfield SG, Tang T, Malloy D, Blanco D, Disciglio RS, Chi RW. Doula care across the maternity care continuum and impact on maternal health: Evaluation of doula programs across three states using propensity score matching. EClinicalMedicine. 2022 Jul 1;50:101531. doi: 10.1016/j.eclinm.2022.101531. PMID: 35812994; PMCID: PMC9257331. https://pmc.ncbi.nlm.nih.gov/articles/PMC9257331/ . This study was conducted using Medicaid recipient records and matched the subjects by state, age, race/ethnicity, socioeconomic status and other factors to ensure direct comparison.

as an evidence-based intervention that improves maternal health, patient satisfaction, health care experiences, and breastfeeding outcomes."[7] Despite improved health outcomes, only approximately 6% of U.S. births involve doula services.[8]

"Community doulas" or "community-based doulas" provide doula services to under-resourced and marginalized populations at low- or no-cost, most often through community-based agencies.[9] A tenet of community doulas is providing culturally congruent and competent services to birthing persons of shared cultural communities and languages.[10] Through their lived experiences in the communities they serve, this critical subset of doulas are able to help their clients connect to resources available within their community, such as referrals to social services and housing and food programs.[11] Community doulas are trauma-informed trained to provide services to clients who have complex socioeconomic and environmental issues.[12] The community-based doula care model uses "community strength to scaffold program delivery" and "reject[s] the deficit-based approach[13] commonly used in clinical settings to support under-resourced communities."[14]

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[7] Marshall, C., Nguyen, A., Yang, C., Gómez, A.M. (2023). Understanding Barriers and Facilitators to Payer Investment in Doula Care in California. Berkeley, CA: University of California, Berkeley https://share.berkeley.edu/wp-content/uploads/2024/08/Understanding-Barriers-and-Facilitators-to-Payer-Investment-in-Doula-Care_brief.pdf

[8] Safon CB, McCloskey L, Estela MG, Gordon SH, Cole MB, Clark J. Access to perinatal doula services in Medicaid: a case analysis of 2 states. Health Aff Sch. 2024 Mar 4;2(3):qxae023. doi: 10.1093/haschl/qxae023. PMID: 38756922; PMCID: PMC10986220. https://pubmed.ncbi.nlm.nih.gov/38756922/

[9] Marshall, C., Nguyen, A., Yang, C., Gómez, A.M. (2023). Understanding Barriers and Facilitators to Payer Investment in Doula Care in California. Berkeley, CA: University of California, Berkeley https://share.berkeley.edu/wp-content/uploads/2024/08/Understanding-Barriers-and-Facilitators-to-Payer-Investment-in-Doula-Care_brief.pdf

[10] Id.

[11] Alvarado G, Schultz D, Malika N, Reed N. United States Doula Programs and Their Outcomes: A Scoping Review to Inform State-Level Policies. Womens Health Issues. 2024 Jul-Aug;34(4):350-360. doi: 10.1016/j.whi.2024.03.001. Epub 2024 May 9. PMID: 38724343. https://www.whijournal.com/article/S1049-3867(24)00021-5/fulltext

[12] Marshall, C., Nguyen, A., Yang, C., Gómez, A.M. (2023). Understanding Barriers and Facilitators to Payer Investment in Doula Care in California. Berkeley, CA: University of California, Berkeley https://share.berkeley.edu/wp-content/uploads/2024/08/Understanding-Barriers-and-Facilitators-to-Payer-Investment-in-Doula-Care_brief.pdf

[13] Community doulas are part of an "asset-based approach" to support underserved communities, meaning community strengths and assets are used to give community members more control over their health; whereas in a deficit-based approach, solutions for identified problems or deficiencies are often developed outside of a community. Martin-Kerry J, McLean J, Hopkins T, Morgan A, Dunn L, Walton R, Golder S, Allison T, Cooper D, Wohland P, Prady SL. Characterizing asset-based studies in public health: development of a framework. Health Promot Int. 2023 Apr 1;38(2):daad015. doi: 10.1093/heapro/daad015. PMID: 36932994; PMCID: PMC10024477. https://pmc.ncbi.nlm.nih.gov/articles/PMC10024477/#:~:text=A%20deficit%2Dbased%20approach%20identifies,Morgan%20and%20Ziglio%2C%202007).

[14] Zainab Sulaiman, MSc, Vice President of Impact and Advocacy, HealthConnect One Melissa Mullins, MPA, University of California, Berkeley, Goldman School of Public Policy
"Getting Doulas Paid: Advancing Community-Based Doula Models in Medicaid Reimbursement Conversations." At p.3. Accessed December 2024. https://healthconnectone.org/wp-content/uploads/2023/02/Getting-Doulas-Paid-Advancing-Community-Based-Doula-Models-In-Medicaid-Reimbursement-Conversations.pdf

B. Maternal Health Crisis in the United States

Maternal mortality in the United States is high and has risen sharply in recent years from 20.1 deaths per 100,000 live births in 2019 to 32.2 deaths per 100,000 live births in 2021.[15] The U.S. has the highest maternal mortality rate among developed countries.[16] In the United States, there are substantial disparities in maternal health outcomes among various populations:

> In 2021, non-Hispanic Black birthing people had more than twice the maternal mortality risk of their non-Hispanic white counterparts. Survey data show that Black birthing people were more likely to report unfair treatment by providers due to their race, decreased decision autonomy during labor, and feeling pressured into cesarean births. People with Medicaid coverage echoed reports of disrespectful treatment because of their insurance status, decreased decision autonomy during labor, no postpartum visits, and less support after childbirth. Infant outcomes also reflect disparities: infants born to Black mothers are twice as likely to die in their first year and more likely to be premature, have low birthweight, and face risk factors associated with infant mortality in comparison to white newborns.[17]

Rural populations and Native American birthing people also have significantly increased rates of mortality due to pregnancy-related complications.[18] Medicaid covers more than 40% of all births in the U.S., including 65% of births among Black pregnant people and 59% of births among Hispanic pregnant people.[19] As compared to individuals with private health insurance, Medicaid recipients are more than 80% more likely to experience Severe Maternal Morbidity,[20] which the Centers for Disease Control and Prevention defines as including "unexpected outcomes of labor and delivery that can result in significant short- or long-term health consequences."[21]

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[15] Alvarado G, Schultz D, Malika N, Reed N. United States Doula Programs and Their Outcomes: A Scoping Review to Inform State-Level Policies. Womens Health Issues. 2024 Jul-Aug;34(4):350-360. doi: 10.1016/j.whi.2024.03.001. Epub 2024 May 9. PMID: 38724343. https://www.whijournal.com/article/S1049-3867(24)00021-5/fulltext

[16] Falconi AM, Bromfield SG, Tang T, Malloy D, Blanco D, Disciglio RS, Chi RW. Doula care across the maternity care continuum and impact on maternal health: Evaluation of doula programs across three states using propensity score matching. EClinicalMedicine. 2022 Jul 1;50:101531. doi: 10.1016/j.eclinm.2022.101531. PMID: 35812994; PMCID: PMC9257331. https://pmc.ncbi.nlm.nih.gov/articles/PMC9257331/

[17] Alvarado G, Schultz D, Malika N, Reed N. United States Doula Programs and Their Outcomes: A Scoping Review to Inform State-Level Policies. Womens Health Issues. 2024 Jul-Aug;34(4):350-360. doi: 10.1016/j.whi.2024.03.001. Epub 2024 May 9. PMID: 38724343. https://www.whijournal.com/article/S1049-3867(24)00021-5/fulltext

[18] https://www.whitehouse.gov/wp-content/uploads/2022/06/Maternal-Health-Blueprint.pdf

[19] Safon CB, McCloskey L, Estela MG, Gordon SH, Cole MB, Clark J. Access to perinatal doula services in Medicaid: a case analysis of 2 states. Health Aff Sch. 2024 Mar 4;2(3):qxae023. doi: 10.1093/haschl/qxae023. PMID: 38756922; PMCID: PMC10986220. https://pubmed.ncbi.nlm.nih.gov/38756922/

[20] Id.

[21] https://www.cdc.gov/maternal-infant-health/php/severe-maternal-morbidity/index.html#:~:text=Severe%20maternal%20morbidity%20(SMM)%20includes,steadily%20increasing%20in%20recent%20years. Accessed December 15, 2024.

Doula care is recognized as an effective tool to improve maternal health outcomes and reduce disparities and inequities among pregnant individuals belonging to marginalized, socioeconomically disadvantaged, and minority populations.

Only by strengthening relationships within the maternal health ecosystem can we strive to ensure that all women receive the care and support they need to have safe pregnancies and childbirth experiences, ultimately improving the health and well-being of mothers and communities alike.

Dr. Karen McDonnell, PhD
Milken Institute of Public Health, George Washington University[22]

In June 2022, the White House recognized community-based doulas as critical support for addressing the maternal health crisis and reducing racial, economic, environmental, and societal inequities in maternal care nationwide.[23] The White House Blueprint for Addressing the Maternal Health Crisis identified the need to expand the perinatal support workforce, including non-clinical professionals like community-based doulas. The Blueprint further advocated for Medicaid coverage up to 12 months postpartum in order to increase equitable access to diverse care and reduce rates of pregnancy complications.[24]

[22] "Considering Maternal Health Disparities: Proceedings of a Workshop Series - in Brief." National Academies of Sciences, Engineering, and Medicine. 2024. Considering Maternal Health Disparities: Proceedings of a Workshop Series—in Brief. Washington, DC: The National Academies Press. doi: 10.17226/28038. https://nap.nationalacademies.org/catalog/28038/considering-maternal-health-disparities-proceedings-of-a-workshop-series-in

[23] Roux, M. Expanding and Diversifying the Doula Workforce: Challenges and Opportunities of Increasing Insurance Coverage. 2023 May. Women's Bureau, U.S. Department of Labor. https://www.dol.gov/sites/dolgov/files/WB/WB_issuebrief-doulas-v3.pdf

[24]The White House. White House Blueprint for Addressing the Maternal Health Crisis. June 2022. https://www.whitehouse.gov/wp-content/uploads/2022/06/Maternal-Health-Blueprint.pdf

Vermont Legislation: Act 97 (2024)
An Act Relating to Medicaid Coverage for Doula Services

In 2024, the Vermont General Assembly considered S.109, proposed legislation relating to Medicaid coverage for doula services. The testimony and materials presented to the Legislature included:

- The U.S. maternal mortality rate rose sharply during the COVID-19 pandemic, with the deaths of approximately 1,200 birthing persons in 2021.[25]
- The maternal mortality rate for non-Hispanic Black people was nearly three times the rate for non-Hispanic white people.[26]
- According to the CDC, over 60% of maternal deaths were preventable.[27]
- Incidents of cesarean delivery for birthing persons who had doula care was over 50% lower than those without doulas.[28]
- Incidents of postpartum depression and anxiety for birthing people who had doula care were approximately 60% lower than for those without doulas.[29]
- 2021 and 2022, approximately 38% of births in Vermont were covered by Medicaid.[30]
- 2021-2023, all eight perinatal deaths in Vermont were of individuals receiving Medicaid whose deaths related to substance use during the postpartum period, most occurring between 3-12 months postpartum.[31]

In response to this testimony and evidence, the General Assembly passed the legislation regarding Medicaid coverage for doula services, enacted as Act 97 (2024), which included the following directive:

> *The Office of Professional Regulation, in consultation with interested stakeholders, shall undertake a review of doulas in accordance with 26 V.S.A. Chapter 57 to determine the appropriate form of regulation for the profession. For purposes of this review, and in accordance with 26 V.S.A. §3105(b), the General Assembly finds that it is necessary for the State to regulate doulas.*[32]

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[25] https://legislature.vermont.gov/Documents/2024/WorkGroups/Senate%20Health%20and%20Welfare/Bills/S.109/Witness%20Documents/S.109~Rebecca%20Copans~BlueCrossBlueShield%20Witness%20Testimony~1-18-2024.pdf

[26] Id.

[27] Id.

[28] Falconi AM, Bromfield SG, Tang T, Malloy D, Blanco D, Disciglio RS, Chi RW. Doula care across the maternity care continuum and impact on maternal health: Evaluation of doula programs across three states using propensity score matching. EClinicalMedicine. 2022 Jul 1;50:101531. doi: 10.1016/j.eclinm.2022.101531. PMID: 35812994; PMCID: PMC9257331. https://pmc.ncbi.nlm.nih.gov/articles/PMC9257331/

[29] Id.

[30] https://legislature.vermont.gov/Documents/2024/WorkGroups/Senate%20Health%20and%20Welfare/Mental%20Health/W~Maria%20Rossi~Washington%20County%20Mental%20Health%20Testimony~1-23-2024.pdf

[31] Stalberg, I. Maternal Mortality Review Panel: 2024 Report to the Vermont Legislature In Accordance with 18 V.S.A. § 1552. (January 15, 2024). Vermont Agency of Human Services, Department of Health. https://legislature.vermont.gov/assets/Legislative-Reports/2024-MMRP-Report-Final.pdf

[32] https://legislature.vermont.gov/Documents/2024/Docs/ACTS/ACT097/ACT097%20As%20Enacted.pdf

Title 26, Chapter 57 statutes contain the "Sunrise Review" criteria the State analyzes to establish "there is a demonstrated need for the State to protect the interest of the public by restricting entry into the profession or occupation." 3 V.S.A. § 3101(a).

> A profession or occupation shall be regulated by the State only when:
>
> (1) it can be demonstrated that the unregulated practice of the profession or occupation can clearly harm or endanger the health, safety, or welfare of the public, and the potential for the harm is recognizable and not remote or speculative;
>
> (2) the public can reasonably be expected to benefit from an assurance of initial and continuing professional ability; and
>
> (3) the public cannot be effectively protected by other means.[33]

As stated in Act 97 (2024), the General Assembly has already found the regulation of Doulas necessary. The remainder of this Sunrise Review will center on analyzing which form of regulation is the least restrictive to protect the public.

Sunrise Process

A. Stakeholder Engagement

For assistance in determining the least restrictive form of regulation necessary, OPR engaged with many stakeholders around the State through meetings and public comment. Stakeholder engagement included seven meetings with doulas, community-based doulas, and individuals from Designated Agencies, State agencies, and advocacy organizations. Additionally, OPR held two hybrid public hearings so that participants could attend either in person at the Agency in Montpelier or online via the Microsoft Teams platform. These hearings were noticed on OPR's Regulatory Review page for Assessment of Doulas as a Licensed Profession in Vermont.[34] One hearing was held during the day and had 23 non-OPR attendees. The other hearing was held in the evening and six non-OPR participants attended. OPR also shared with stakeholders, meeting attendees, and on its website a public comment email address (sos.opr.comments@vermont.gov) with a public comment period that closed in mid-November.

Approximately 20 individuals provided testimony at the hearings and/or public comments, including doulas providing services in Vermont, individuals representing advocacy groups in favor of doula regulation for Medicaid reimbursement, individuals who utilized perinatal doula services, a physician/professor, and multiple certified nurse midwives.

[33] 26 V.S.A. § 3105.

[34] https://sos.vermont.gov/opr/regulatory/regulatory-review/doulas/

B. Stakeholder Feedback

Participants expressed overwhelming support for certification as the desired form of regulation. Many identified the need to carefully name the profession to avoid disruption of nationally certified independent practitioners, often referred to as "Certified Doulas," who do not want to bill Medicaid and/or do not want State certification. Participants also acknowledged the need for training and emphasized imposing strict requirements that mandate national certifications or expensive coursework before licensure would create unacceptable burdens for community-based doulas. Such burdens would act as barriers that are contrary to the public policies supporting regulation and expanding the workforce. Stakeholders strongly expressed that multiple pathways honoring legacy practitioners and experience must be offered so that doulas from diverse communities, cultures, and socioeconomic backgrounds would have access and opportunity to become State-certified.

- ***Certified Nurse Midwife:*** *For communities of color, who have long been underserved by medical systems, a community-based doula model is essential. Doulas from these communities, who share racial, ethnic, and linguistic backgrounds with their clients, offer culturally sensitive support and help address healthcare gaps. In a healthcare system that is often difficult to navigate community-based doulas build trust and can be transformative for minoritized groups who may not feel comfortable in traditional medical settings. To ensure equitable access, we must resist restrictive regulations that could further limit the diversity of the doula workforce.*

- ***Nationally Certified Doula:*** *I would love to see Vermont invest in young families' health and well-being by providing a birth doula to every family who wants one.*

- ***Certified Nurse Midwife:*** *I appreciate that the State of Vermont is moving in the direction of Medicaid reimbursement for Doula services. I also understand that this leads to the need for regulation for this profession to protect consumer safety. My focus is the State must balance protecting quality of care with ensuring fair access for doulas who want to serve or who are already serving, Medicaid populations.*

- ***Certified Nurse Midwife:*** *I work in Chittenden County with the New American population of immigrants and refugees. Their needs are definitely not being met. I would like to see them have access to culturally congruent doula services to assist with their navigation of the health care system as well improve their birth outcomes and experiences in the hospital.*

- ***Certified Nurse Midwife****: Any training or certification requirement that doulas must meet to be eligible for reimbursement from Medicaid must be flexible and not constitute an undue burden for doulas or serve as an excessive barrier to practice. Many of the national training organizations required for credentialing are typically white-led and may not offer training to meet the needs of diverse communities. To address this challenge, states are considering doula training approaches that are culturally reflective of the communities served, and accessible to a wide range of doulas. Considerations include training costs, duration, and number of and location*

of training courses. Rather than provide a list of certification organizations and require that a doula be certified by one of the organizations on the list, states can consider instead, or also, allowing doulas to meet a set of core training competencies that are not tied to a specific organization.

- ***MD/Professor:*** *In the context of the diverse needs of our Vermont Medicaid recipients, including a substantial number of New Americans from a number of different regions, speaking a number of different primary languages, doula training or certification for Medicaid reimbursement eligibility should be flexible and not result in barriers to prospective doulas. Additionally, in the context of our very small state with fewer births than any other state in the US except Wyoming, training and certification should include a focus on privacy and HIPPA, in addition to the more standard doula-care training foci.*

- ***Doula/Co-Director of a Doula Organization:*** *Regulatory action around the country has only become important in recent years, specifically and narrowly, and as is the case in Vermont, to help facilitate the increasingly popular state-level policy of providing Medicaid reimbursement for perinatal doula services, which requires assurances of competencies and a mechanism for accountability…[O]f the three potential regulatory pathways offered by Vermont's Office of Professional Regulation, the Certification pathway provides these things. Additionally, it can also provide a value-add to the growth of a workforce that is highly qualified to support families with potentially complex needs by promoting a model designed for more community-based and expanded support than is typical with standard doula services.*

- ***Certified Nurse Midwife:*** *I recognize that this will likely require some sort of standardization of certification. While I understand the goal of this, it does concern me that we may not be able to utilize some of our best doulas, who can offer the gift of culturally appropriate care to birthing families. In this vein, I support a "legacy pathway" or "experience pathway," which is a way to credential doulas who have significant experience but do not have recent formal training." This pathway can be defined as attending a certain number of births or hours of care. In Oregon, for instance, the legacy pathway is defined as "attending 10 births and providing 500 hours of work supporting birthing persons and families as a birth doula."*

- ***Certified Nurse Midwife:*** *Doula support, from someone who looks like the client and understands their culture is a critical need. There are exciting opportunities in our New American population to have community doulas trained - these might be people who were midwives in their home country. They will need compensation (be able to bill) to provide this vital support in order to step away from other job or family responsibilities. Expensive training and licensure will make that impossible for most people. Connection with a community doula has the potential to improve health outcomes for families in general, as they can be connectors to other supports.*

Analysis of Chapter 57 Factors: OPR Recommends CERTIFICATION as the Appropriate Form of Regulation.

A. Regulation of Community Doulas is Warranted for Public Protection.

As described above, as part of its consideration of S.109, the Vermont General Assembly heard testimony that underscored disparate maternal mortality and health outcomes for birthing persons and their babies from under-resourced and marginalized communities, where opportunities to benefit from doula care do not exist because of a lack of resources and/or lack of access to culturally congruent and competent doula services. Based on the legislative record, the intended regulatory purpose of the doula profession is to ensure equitable access to doula care for birthing persons in under-resourced and marginalized communities to improve health outcomes.

Birthing people of financial means who are not from historically marginalized communities have access to private-pay doulas working primarily within well-resourced populations and a culturally congruent medical care system. In this review, OPR did not find information indicating that systemic harm is occurring within those population segments or that there is a public protection need for regulation of private-pay doulas for clients who are not from disadvantaged communities. The 6% of the birthing population that already utilizes private-pay doula services greatly benefits from this additional maternal support with significantly lower c-section rates, lower incidents of postpartum depression and anxiety, lower mortality rates, reduced incidence of low birth weights, and overall better birth experiences. OPR is not aware of data, statistics, or systemic issues within this population that would call for regulation. Any issues or problems arising from a private-pay doula/client relationship in well-served and represented communities could adequately be addressed through civil remedies for breach of contract or potential tort action or by the criminal justice system in rare cases of fraud, theft, or other crime.

The purpose of the proposed doula regulation is to make the health benefits of doula care available for all birthing people in Vermont, irrespective of resources. Community-based doulas serve Vermont's most vulnerable birthing population. Community Doulas are a subset of the profession for which specialized training and experience may be valuable indicators for consumers and insurers that they have the competencies necessary to serve communities experiencing disparate health outcomes resulting from: systemic biases, structural racism, poverty, substance use disorder, mental health disorders, housing insecurity, trauma histories, developmental disabilities, and the like. Community doulas in Vermont have not previously been regulated. As previously noted, they serve a population that is uniquely vulnerable and, as a result, Medicaid should cover these services. For Vermont to provide public funding for doula services through Medicaid, regulation of this sub-group of qualified doulas is necessary.

B. Review of Statutory Factors to Identify Least Restrictive Form of Regulation

To determine the least restrictive form of regulation necessary, Vermont law requires consideration of the guiding statutory factors set forth in the following table.[35]

Statutory Criteria	Analysis
(1) If existing common law and statutory civil remedies and criminal sanctions are insufficient to reduce or eliminate existing harm, regulation should occur through enactment of stronger civil remedies and criminal sanctions	Inapplicable - poor maternal outcomes from lack of access to culturally congruent/competent maternal care in marginalized communities cannot be reduced by civil and criminal remedies.
(2) If a professional or occupational service involves a threat to the public and the service is performed primarily through business entities or facilities that are not regulated, the business entity or the facility should be regulated rather than its employee practitioners.	Doulas are autonomous, individual practitioners. Any threat to the public potentially derives from lack of culturally competent training or intentional individual misconduct. Doulas may be self-employed, employed by businesses, or employed by community-based organizations or agencies. Regulation of business entities would not mitigate any threat.
(3) If the threat to the public health, safety, or welfare, including economic welfare, is relatively small, regulation should be through a system of registration.	Threat to particular communities posed by lack of culturally competent, accessible maternal care is significant. However, mandatory registration would result in impermissible overregulation of the profession (see further discussion below).
(4) If the consumer may have a substantial interest in relying on the qualifications of the practitioner, regulation should be through a system of certification.	Consumers of doula services, as well as insurers, may have substantial interest in relying on the qualifications of community-based doulas
(5) If it is apparent that the public cannot be adequately protected by any other means, a system of licensure should be imposed.	It appears the public can be adequately protected through a less restrictive form of regulation, namely certification.

[35] 26 V.S.A. § 3105(b).

C. OPR Does Not Recommend Registration

The least restrictive form of mandatory occupational regulation, registration, requires no education or qualifications.[36] A registrant simply submits an application notifying OPR that the individual is engaged in the practice of the profession and pays a fee.[37] Trainings, coursework, experience, or demonstrated competencies are not required for initial registration, nor are continuing competencies assessed or required for renewal of the registration. In addition, as noted above, registration is required of all individuals practicing the profession. In registration professions, OPR maintains a list of those in the profession and has enforcement authority when practitioners engage in unprofessional conduct.[38]

Registration of all doulas would not help to mitigate harms of disparate treatment of under-resourced and marginalized birthing persons in maternal health care systems. In the doula profession, there is significant interest in reliance upon the training of community-based doulas to provide culturally competent maternal care and avoid exacerbating an already troubled system fueled by inequitable care of birthing persons in underserved communities. Untrained community-based doulas have the potential to create greater patient distrust of maternal health care systems, which could result in pregnant patients not seeking needed maternity care. Thus, a form of regulation that provides a market signal of competence and qualification for community doulas is important.

As noted above, OPR did not receive evidence of harm arising from the doula workforce practicing in well-served, well-represented, adequately resourced communities that have access to necessary care and culturally congruent medical services. Registration of doulas as a profession would result in unnecessary overregulation of all practitioners. OPR does not recommend registration of doulas as the appropriate form of regulation.

D. OPR Does Not Recommend Licensure

Licensure is the most restrictive form of occupational regulation, mandating qualifications for all professionals prior to practice. Qualifications often include formal education, as well as testing and experiential requirements. Similarly to registration, licensure would result in unnecessary overregulation of all doulas. Without evidence of harm caused by the unlicensed practice of private-pay doulas working in well-resourced and well-represented communities of individuals who have access to medical care, requiring licensure of all doulas would result in impermissible regulatory overreach.

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[36] 26 V.S.A. § 3105(b)
[37] Applications for registration are approved except in cases where disclosure of criminal histories results in enforcement review for unprofessional conduct under 3 V.S.A. § 129a.
[38] See 3 V.S.A. § 129a, OPR's Unprofessional Conduct statute that applies to all OPR-regulated professions.

Moreover, licensure requirements often create insurmountable financial or resource barriers for practitioners from marginalized, under-resourced, and underserved communities. Such barriers would be antithetical to the purpose of regulating community-based doulas, i.e. creating representation in maternal health systems. Affordable training and credentialing processes are critical to building and supporting the culturally congruent workforce providing perinatal services to disadvantaged people. As one stakeholder observed:

> *Licensure, while it would attach competencies to credentialing, would also diverge from the impetus and spirit of Act. 97: this was to create the apparatus to support this type of specialized workforce while protecting the businesses and credentialing investments many doulas have already made, and recognizing the invaluable work of many non-credentialed community doulas who have long supported their clients and peers in highly culturally-competent ways.*

Requiring licensure of all doulas causes overregulation of one segment of the doula workforce and imposes cost-prohibitive, resource-intensive barriers for the intended regulated segment of the workforce, community-based doulas. As discussed below, the public can be adequately protected through the alternative regulatory form of certification; therefore, OPR does not recommend licensure of doulas as the appropriate form of regulation.

E. OPR Recommends Voluntary Certification of Community-Based Perinatal Doulas

In light of the startling increases in poor maternal outcomes and morbidities, birthing persons from vulnerable affected populations have a substantial interest in relying on the training and qualifications to demonstrate competency of community-based perinatal doula services offered at low- or no-cost.[39] The title of "State-Certified" or "Certified" would be a significant market signal for individuals or public or private insurers to identify qualified community-based practitioners. Therefore, OPR recommends voluntary certification as the appropriate form of regulation.

However, for such State certification to be an effective tool for Vermont consumers, the profession name must be sufficiently narrowed to identify the regulated segment of the doula workforce, particularly since certification of doulas by various national organizations is commonplace. In consultation with stakeholders, OPR suggests the profession name of "Community-Based Perinatal Doulas"[40] to denote the regulated workforce as a smaller subset of doulas, as well as the phase of life for clients being served as related to birth.[41]

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[39] 26 V.S.A. § 3105(b).
[40] Perinatal means the period of time before, during, and after birth.
[41] There are also doulas who provide services relating to end of life.

Due to access issues and costs, Vermont stakeholders emphasized the strong desire to avoid a single, prescribed pathway of certification from a national organization. To implement an accessible, successful community-based doula certification program, OPR will engage with stakeholders in the legislative and rulemaking processes to identify multiple, flexible pathways to recognize the qualifications of specified community-based doula competencies. Such pathways may include experience, mentorship, community training, more formal coursework or education, or a combination of these. For legacy doulas who have been practicing in community-based settings, OPR anticipates implementing some form of recognition of their experience along with documentation and verification of the competencies from their associated organizations. As one stakeholder shared:

> *Doula support is a powerful tool to address the crises we all face in perinatal healthcare and the impacts that birth trauma, perinatal mood and anxiety disorders, lack of access to evidence-based information and compassionate support have on Vermont families…I strongly believe that beyond a list of well-known doula training organizations, doulas who have gained experience should be included in those that can be certified.*

Act 97 anticipates the creation of State-certified community-based doulas in Vermont will lead to Medicaid coverage of trained doula services, making them available to communities that have not previously had such access. The critical public benefit of this new regulation is building a workforce with culturally congruent professionals who have lived experience in underserved and marginalized communities and are trained to serve birthing persons with complex socioeconomic and environmental challenges competently. This type of accessible qualified care connects patients and their families to community resources and supports, reducing poor maternal outcomes and yielding benefits beyond the birthing process.

OPR will need to set up the infrastructure to regulate this profession. Previously OPR provided a cost estimate of $25,000 to establish the profession within the Agency's structure, including staff time, technology costs, stakeholder outreach, and rulemaking.[42]

Once doula legislation is enacted, the next step will be the rulemaking process, in which OPR will collaborate with stakeholders, sister agencies, and the public. In rulemaking, OPR will work closely with the Department of Vermont Health Access (DVHA) to ensure that credentialing pathways created in the administrative rules meet federal requirements necessary for Medicaid billing by Certified Community-Based Perinatal Doulas.

[42] Vermont Legislature Joint Fiscal Office, Fiscal Note: S.109 – An act relating to Medicaid coverage for doula services. 2024 February 7. https://ljfo.vermont.gov/assets/Publications/2023-2024-Senate-Bills/cd068d9802/GENERAL-374255-v7-2024_S_109_Doulas-SENATE-PASSED.pdf

F. Doula Requirements in Other States

Many states that provide Medicaid coverage for doula services require doulas to have certification or training from pre-approved organizations or programs, often national or international organizations that cost hundreds or thousands of dollars.[43] Certification is commonplace in the doula community:

> As of mid-2018, over 100 independent organizations offered some form of doula training and certification. These organizations include large-scale training organizations, such as DONA International and Childbirth and Postpartum Professional Association (CAPPA), as well as local and community-based training programs.[44]

Though common in the profession, not all doulas obtain certifications from national or local organizations. Many have years of experience working with pregnant, birthing, and postpartum individuals from within their own ethnic or cultural communities, socioeconomic groups or other marginalized or disadvantaged populations.

At this time, researchers and public policy analysts discourage stringent and expensive credentialing requirements, as they contradict policy change efforts to ensure access for doulas as well as increased access to services for community-based clients.[45]

California, Rhode Island, and Oregon offer flexible pathways for the qualification of doulas.[46] None of these states limit doula qualification to completion of state-approved programs. Rhode Island requires specified training hours in designated competencies demonstrated by course certificates or self-attestation with attached course syllabi.[47] California and Oregon have pathways for legacy doulas to demonstrate competency through documented or verified experience rather than formal training.[48]

OPR will look to models in other states and engage with stakeholders to identify and implement minimal, flexible qualification pathways for Vermont to certify competent community-based doulas. OPR will also work closely with DVHA to ensure that credentialing

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[43] Chen, A., Rohde, K. Doula Medicaid Training and Certification Requirements: Summary of Current State Approaches and Recommendations for Improvement. 2023 March 16. National Health Law Program. https://healthlaw.org/doula-medicaid-training-and-certification-requirements-summary-of-current-state-approaches-and-recommendations-for-improvement/

[44] Id.

[45] Safon CB, McCloskey L, Estela MG, Gordon SH, Cole MB, Clark J. Access to perinatal doula services in Medicaid: a case analysis of 2 states. Health Aff Sch. 2024 Mar 4;2(3):qxae023. doi: 10.1093/haschl/qxae023. PMID: 38756922; PMCID: PMC10986220. https://pubmed.ncbi.nlm.nih.gov/38756922/

[46] Chen, A., Rohde, K. Doula Medicaid Training and Certification Requirements: Summary of Current State Approaches and Recommendations for Improvement. 2023 March 16. National Health Law Program. https://healthlaw.org/doula-medicaid-training-and-certification-requirements-summary-of-current-state-approaches-and-recommendations-for-improvement/

[47] Id.

[48] Id.

requirements created through the administrative rulemaking process satisfy federal Medicaid billing requirements.

Conclusion

In response to the Legislative directive in Act 97 (2024), Vermont Office of Professional Regulation has conducted a Sunrise Review of doulas as a regulated profession in consultation with stakeholders. OPR has considered statutory factors from Title 26, Chapter 57 and determined that Certification of Community-Based Perinatal Doulas is the appropriate form of regulation.

Research relating to Medicaid coverage for doulas has revealed that stringent State requirements or national certification pathways act as barriers preventing qualified individuals from becoming doulas who serve their own marginalized communities. Therefore, OPR will engage with stakeholders and VDHA in the legislative and rulemaking process to determine flexible, accessible pathways for state certification that satisfy federal Medicaid requirements.

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