Maryland
DEPARTMENT OF HEALTH

Board of Nursing

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Secretary

December 1, 2021

The Honorable Paul G. Pinsky
Chairman, Education, Health, and Environmental Affairs Committee
Maryland Senate
Miller Senate Office Building, 2 West Wing
11 Bladen St.
Annapolis, MD 21401

The Honorable Shane E. Pendergrass
Chairman, Health and Government Operations Committee
Maryland House of Delegates
House Office Building, Room 241
6 Bladen St.
Annapolis, MD 21401

Re: Report Required by Health Occupations Article § 8-6C-12(c) – Fiscal Year 2021

Dear Senator Pinsky and Delegate Pendergrass,

The Maryland Board of Nursing (the "Board") submits this report to the Senate Education, Health, and Environmental Affairs Committee and the House Health and Government Operations Committee as required by the Annotated Code of Maryland, Health Occupations Article ("Health Occ.") § 8-6C-12(c), which provides:

> Beginning December 1, 2016, and on each December 1 thereafter, the Board shall submit to the Senate Education, Health, and Environmental Affairs Committee and the House Health and Government Operations Committee, in accordance with § 2-1257 of the State Government Article:
>
> (1) The report submitted to the Board [by the Direct-Entry Midwifery Advisory Committee] under subsection (a)(1) of this section;
>
> (2) In consultation with the [Direct-Entry Midwifery Advisory] Committee, any recommendations regarding the continuation and improvement of the licensure of licensed direct-entry midwives in the State;
>
> (3) Any recommendations regarding expanding the scope of practice of licensed direct-entry midwives; and

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(4) Any recommendations, including recommendations for legislation, regarding the scope of practice of licensed direct-entry midwives to include vaginal birth after cesarean.

Attached, please find a copy of the Direct-Entry Midwifery Advisory Committee's Annual Report to the Board required by Health Occ. § 8-6C-12(a)(10).

The Board received and reviewed the Direct-Entry Midwifery Advisory Committee's Annual Report during the open session of the November 17, 2021 Board meeting. Following review, the Board voted to adopt the Direct-Entry Midwifery Advisory Committee's Annual Report, as submitted and without any changes, including the Direct-Entry Midwifery Advisory Committee's recommendations regarding expanding the scope of practice of licensed direct-entry midwives, to include vaginal birth after cesarean.

If there are any questions related to this correspondence, the Board's recommendations, or the attached Direct-Entry Midwifery Advisory Committee's Annual Report, please feel free to contact me at mbon.hicks@maryland.gov or the Board's Executive Director, Karen E.B. Evans, at karene.evans@maryland.gov or by telephone at 410-585-1914.

Sincerely,

Gary Hicks, RN, CEN, CNE
President, Maryland Board of Nursing
-and-
Members of the Maryland Board of Nursing

Cc: The Honorable William C. Ferguson, President of the Senate
The Honorable Adrienne A. Jones, Speaker of the House
Sarah Albert, Department of Legislative Services (5 copies)

Enclosure: Direct-Entry Midwifery Advisory Committee's "FY 2021 Report for Licensed Direct-Entry Midwives as Required by Health Occupations Article, Title 8, Section 8-6C-12(a)(1), Annotated Code of Maryland"

Maryland
DEPARTMENT OF HEALTH

Board of Nursing

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Secretary

MEMORANDUM

To: Maryland Board of Nursing (the "Board")

From: Direct-Entry Midwifery Advisory Committee (the "Committee")
Monica Mentzer, Manager of Practice

Date: November 17, 2021

Re: FY 2021 Report for the Licensed Direct-Entry Midwives ("DEMs")
Required by Health Occupations Article, Title 8,
Section 8-6C-12(a)(10), Annotated Code of Maryland

The Committee respectfully submits this memorandum to the Board for its review. Specifically, this memorandum provides a summary of data that the Committee collects from DEMs on an annual basis as well as the Committee's recommendations regarding: (1) the continuation and improvement of licensure of DEMs in Maryland; (2) expanding the scope of practice of licensed DEMs; and (3) scope of practice of licensed DEMS to include vaginal birth after cesarean.

I. Summary of Data Collected Annually from DEMs

Pursuant to Md. Code Ann., Health Occupations Article ("Health Occ.") § 8-6C-10(a), each DEM shall report annually to the Committee, in a form specified by the Board (the "Data Collection Form"), certain information regarding cases in which the DEM assisted during the previous fiscal year when the intended place of birth at the onset of care was an out-of-hospital setting. Pursuant to Health Occ. § 8-6C-12(a)(10), the Committee shall submit a report to the Board that includes a summary of the information included in the Data Collection Forms that the Committee received (the "Report").

Below, please find the report completed by the Committee pursuant to Health Occ. § 8-6C-12(a)(10). For purposes of the Report, the data provided is for the period from July 1, 2020 to June 30, 2021, fiscal year 2021. During the reporting period, there were 30 DEMs licensed to practice in Maryland.[1]

[1] Out of the 30 Data Collection Forms that the Committee received and reviewed, one did not complete multiple questions, while indicating 0 or not applicable for others. The DEM reported on this Data Collection Form that they had moved out of the State of Maryland prior to the reporting period.

(1) The total number of patients served as primary caregiver at the onset of care

Total Number: 498[2]

(2) The number, by county, of live births attended as primary caregiver:

Total Number: 349[3]

Allegany County	1	Harford County	12
Anne Arundel County	12	Howard County	18
Baltimore City	26	Kent County	1
Baltimore County	37	Montgomery County	34
Calvert County	4	Prince George's County	38
Caroline County	0	Queen Anne's County	4
Carroll County	15	St. Mary's County	66
Cecil County	18	Somerset County	1
Charles County	12	Talbot County	1
Dorchester County	4	Washington County	10
Frederick County	30	Wicomico County	2
Garrett County	1	Worcester County	2

[2] Out of the 30 Data Collection Forms that the Committee received and reviewed, four did not complete this question. One DEM reported on this Data Collection Form that they had moved out of the State of Maryland. *See* Footnote 1.

However, the remaining three of these incomplete Data Collection Forms did complete Question #2, indicating number of live births attended as primary caregiver in one or more of Maryland's counties. Therefore, this number reflects the data collected from 26 DEMs. In light of this, the Committee believes the total number of clients served as primary caregiver at onset of care may be higher than what is reflected in this Report. The Committee will re-examine the Data Collection Form to see if it can clarify this question further to ensure accurate completion.

[3] This number is the total summation of the number of cases reported by County under Question 2 in the Data Collection Forms. The Committee believes, but cannot confirm, that a reason for the discrepancy between the total number in response to Question 1 and total number in response to Question 2 may reflect the DEMs' practice outside of the State of Maryland. The Committee will re-examine the Data Collection Form to see if it can clarify this question further to ensure accurate completion.

(3) The number, by county, of cases of fetal demise, infant deaths, and maternal deaths attended as primary caregiver at the discovery of the demise or death:

Total Number: 1[4]

Allegany County	0	Harford County	0
Anne Arundel County	0	Howard County	0
Baltimore City	0	Kent County	0
Baltimore County	0	Montgomery County	0
Calvert County	0	Prince George's County	0
Caroline County	0	Queen Anne's County	0
Carroll County	0	St. Mary's County	0[5]
Cecil County	0	Somerset County	0
Charles County	0	Talbot County	0
Dorchester County	0	Washington County	0
Frederick County	1	Wicomico County	0
Garrett County	0	Worcester County	0

(4) The number of women whose primary care was transferred to another health care practitioner during the antepartum period and the reason for transfer:

Total Number: 33

Number of Women	Reason for Transfer
3	302: Hypertension developed in pregnancy
2	303: Blood coagulation disorders, including phlebitis
1	307: Gestational diabetes
4	310: Loss of pregnancy (includes a spontaneous and elective abortion) when a transfer took place
2	312: Suspected intrauterine growth restriction, suspected macrosomia
3	313: Fetal anomalies
2	314: Abnormal amniotic fluid volumes; oligohydramnios or polyhydramnios
4	316: Non vertex lie at term
1	317: Multiple gestation

[4] The Data Collection Form, that originally reported an infant death for St. Mary's County in response to this question, further explained under Question 9 that the infant's condition, and subsequent death, was discovered after the infant's care had transferred from the DEM to the pediatrician. Further, the DEM reported that there were no symptoms of the condition at the time of birth. On this basis, Committee determined that the infant death did not occur while the DEM attended as primary caregiver at the discovery of the demise or death, and, therefore, this data point should be adjusted to 0.

[5] *See* Footnote 4.

3	318: Clinical judgment of the midwife (when a single other condition does not apply)
7	319: Client choice/non-medical (*e.g.*, client moved, cost/insurance problem, client wanted another provider, midwife-initiated other than due to complications, client chose unassisted birth, midwife provided prenatal care for planned hospital birth, no reason given by client, and *et cetera*)
1	320: Other: "Pre-Term Birth"

(5) The number, reason for, and outcome of each nonemergency hospital transfer during the intrapartum or postpartum period:

Total Number: 40[6]

Reasons for Transfer (and number of transfers for this reason)	Outcomes for Mothers if available (and number of mothers with this outcome)	Outcomes for infants, if available (and number of infants with this outcome)
Reason for intrapartum elective or nonemergency transfers	101: Healthy mother, no serious pregnancy/birth related medical complications (33)	201: Healthy live born infant (32)
501: Persistent hypertension, severe or persistent headache (2)		202: With serious pregnancy/birth related medical complications resolved by 4 weeks (1)
504: Signs of infection (1)		
505: Prolonged rupture of membranes (4)		
506: Lack of progress, maternal exhaustion, dehydration (12)		
507: Thick meconium in the absence of fetal distress (1)		
508: Non-vertex presentation (2)		
509: Unstable lie or malposition of the vertex (1)		
510: Multiple gestation (1)		

[6] One of the Data Collection Forms originally responded to this question with zero, but then wrote in two reasons for transfer. Therefore, the Committee adjusted this total number, by adding two, to include the two reasons for transfer.

In addition, the reasons for transfer total 41, instead of 40, because one of the Data Collection Forms listed two reasons for a single case of transfer.

511: Clinical judgment of the midwife (when a single other condition does not apply) (2)		
512: Client request; request for methods of pain relief (10)		
513: Other – "Pre-term labor" (1)		
Reasons for postpartum maternal elective or non-emergency transfers		
702: Repair of laceration beyond midwife's expertise (3)		
Reasons for nonemergency infant transfers		
907: Clinical judgment of the midwife (when a single other condition does not apply) (1)		

(6) The number, reason for, and outcome of each urgent or emergency transport of an expectant mother in the antepartum period:

Total Number: 11

Reasons for Transfer (and number of transfers for this reason)	**Outcomes for Mothers if available (and number of mothers with this outcome)**	**Outcomes for infants, if available (and number of infants with this outcome)**
402: Severe or persistent headache, pregnancy-induced hypertension)PIH), or preeclampsia (1)	101: Healthy mother, no serious pregnancy/birth related medical complications (11)	201: Healthy live born infant (10)
406: Preterm labor or preterm rupture of membranes (6)		202: With serious pregnancy/birth related medical complications resolved by 4 weeks (1)
407: Marked decrease in fetal movement, abnormal fetal heart tones, non-reassuring non-stress test (4)		

(7) The number, reason for, and outcome of each urgent or emergency transport of an infant or mother during the intrapartum or immediate postpartum period:

Total Number: 12[7]

Reasons for Transfer (and number of transfers for this reason)	**Outcomes for Mothers if available (and number of mothers with this outcome)**	**Outcomes for infants, if available (and number of infants with this outcome)**
Reasons for urgent or emergency intrapartum transfers	101: Healthy mother, no serious pregnancy/birth related medical complications (12)	201: Healthy live born infant (8)
604: Maternal shock, loss of consciousness (1)		202: With serious pregnancy/birth related medical complications resolved by 4 weeks (3)
606: Non-reassuring fetal heart tones and/or signs or symptoms of fetal distress (2)		205: Fetal demise diagnosed during labor or at delivery (1)
Reasons for immediate postpartum maternal urgent or emergency transfers		
803: Uncontrolled hemorrhage (4)		
804: Seizures or unconsciousness, shock (1)		
Reasons for urgent or emergency infant transfers		
351: Abnormal vital signs or color, poor tone, lethargy, no interest in nursing (2)		
352: Signs or symptoms of infection (1)		
362: Clinical judgment of the midwife (when a single other condition does not apply) (1)		
363: Other (1)		

[7] The reasons for transfer total 13, instead of 12, because one of the Data Collection Forms listed two reasons for a single case of transfer.

(8) The number of planned out-of-hospital births at the onset of labor and the number of births completed in an out-of-hospital setting:

Total Number at the onset of labor (*i.e.*, intending to give birth at home/birth center): 326

Total number completed in an out-of-hospital setting (*i.e.*, completed at home/birth center as planned): 294

(9) A brief description of any complications resulting in the morbidity or mortality of a mother or a neonate.[8]

The Data Collection Form, that originally reported an infant death for St. Mary's County in response to Question 3, further explained under Question 9 that the infant's condition, and subsequent death, was discovered after the infant's care had transferred from the DEM to the pediatrician. *See* Footnote 4. Specifically, the Data Collection Form provided the following description under Question 9:

> This note is regarding the infant death noted in question 3. This case is not reflected in question 7 as the transfer did not happen in the immediate postpartum phase, nor by me. The family was referred to the hospital by their pediatrician in the days following the pediatrician's initial exam. This baby was subsequently diagnosed with [redacted as confidential health information], a condition for which there is no treatment and death is certain. There are no symptoms of disease at the time of birth.

The Data Collection Form, that reported Fetal Demise under Questions 3 and 7, explained under Question 9 that the Medical Examiner subsequently found that the fetal demise occurred in utero, prior to labor and delivery, and that the cause of death was "silent abruption."

[8] Please note that the Committee has redacted or otherwise summarized the explanations given under Question 9 of the Data Collection Forms in order to maintain confidentiality of the patients' health information in accordance with applicable laws and regulations.

II. Committee's Recommendations

Additionally, the Committee hereby provides the Board with the following information to assist the Board with providing additional information[9] to the Maryland General Assembly, as outlined in Health Occ. § 8-6C-12(c)(2)-(3):

1. Any Committee recommendations regarding the continuation and improvement of the licensure of licensed direct-entry midwives in the State:

First, the Committee has concerns regarding the lengthy procedures for timely renewal of licensure for DEMs in Maryland. Specifically, the Committee is concerned that renewal applications may not be received sufficiently in advance for the Committee to review and provide its recommendation to the Board for final action prior to expiration.

The Committee recommends amending Title 8, Subtitle 6c to offer DEMs a grace period for renewals. Such grace period already is available to licensed nurses and certified nursing assistants pursuant to Md. Code Ann., Health Occ. § 8-312(d) and § 8-6A-08(f), respectively, providing that the Board "may grant a 30-day extension," beyond the expiration date of the license or certificate so the licensee or certificate holder may renew the license or certificate before it expires.

In addition, the Committee is considering amending the DEMs' licensure renewal application materials to clarify the process for renewal and notify licensed DEMs of the deadline to submit renewal applications, well in advance of expiration of the license to permit Committee and Board review.

Second, the Committee recommends that the Committee and Board re-examine the application fees set forth in COMAR 10.64.01.18 in accordance with Health Occ. § 8-6C-15. The Committee proposes that the fees be reasonably comparable to other licensed and certified professionals under the Board's jurisdiction to the extent that the fees cover the approximate cost of the Board providing licensure and other services to the DEMS.

2. Any recommendations regarding expanding the scope of practice of licensed direct-entry midwives:

Currently, a DEM may not assume responsibility for a patient's pregnancy and birth care if the patient has had a previous uterine surgery, including a cesarean section or myomectomy. *See* Health Occ. § 8-6C-03(11). After careful consideration,

[9] The additional information includes: (1) In consultation with the Committee, any recommendations regarding the continuation and improvement of the licensure of the DEMS in the State; (2) Any recommendations regarding expanding the scope of practice of DEMS; and (3) Any recommendations, including recommendations for legislation, regarding the scope of practice of DEMS to include vagina birth after cesarean. Health Occ. § 8-6C-12(c).

including completion of a study with recommendations at the request of Delegate Ariana Kelly, Chair of the Health Occupations and Long-Term Care Subcommittee of the House's Health and Government Operations Committee, and input from various stakeholders, the Committee recommends expansion of the scope of practice of DEMS to include vaginal birth after cesarean delivery, in certain limited circumstances, as set forth in HB 1032 of the 2020 Legislative Session.

The study report, approved by the Committee by majority vote on October 15, 2021, provides a fuller explanation of the Committee's position in this matter. The study report was submitted to the Board for its knowledge and information review at the Board's Open Session meeting, dated October 27, 2021. The study report was submitted to Delegate Kelly on October 31, 2021.

3. Any recommendations, including recommendations for legislation, regarding the scope of practice of license direct-entry midwives to include vaginal birth after cesarean delivery:

See response to #2 above.

Thank you for this opportunity to update the Board on the activities of the licensed DEMS and the Committee so that the Board can compile its required report to the Maryland General Assembly by December 1, 2021.