Maryland
DEPARTMENT OF HEALTH

Board of Nursing

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

December 1, 2022

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

The Honorable Joseline A. Peña–Melnyk
Chairman, Health and Government Operations Committee
Maryland House of Delegates
House Office Building, Room 241
6 Bladen Street
Annapolis, MD 21401

Re: Report Required by Health Occupations Article § 8-6C-12(c) – Fiscal Year 2022

Dear Senator Pinsky and Delegate Peña–Melnyk,

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

(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 16, 2022 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 2022 Report for Licensed Direct-Entry Midwives as Required by Health Occupations Article, Title 8, Section 8-6C-12(a)(1), Annotated Code of Maryland

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REPORT

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

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

Date: November 16, 2022

Re: FY 2022 Report from the Committee as Required by Health Occupations Article, Title 8, Section 8-6C-12(a)(10), Annotated Code of Maryland

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The Committee respectfully submits this Report to the Board in accordance with the Maryland Nurse Practice Act, Md. Code Ann., Health Occupations Article ("Health Occ.") § 8-6C-12(a)(10). This Report provides a summary of the information reported to the Committee by licensed direct-entry midwives ("DEMs") in accordance with Health Occ. § 8-6C-10 and 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 Health Occ. § 8-6C-10(a), each licensed DEM shall report annually to the Committee, in a form specified by the Board (the "Data Collection Form"), the following 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:

(1) The total number of patients served as primary caregiver at the onset of care;
(2) The number, by county, of live births attended as primary caregiver;
(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;
(4) The number of women whose primary care was transferred to another health care practitioner during the antepartum period and the reason for transfer;
(5) The number, reason for, and outcome of each nonemergency hospital transfer during the intrapartum or postpartum period;
(6) The number, reason for, and outcome of each urgent or emergency transport of an expectant mother in the antepartum period;
(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;

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(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;
(9) A brief description of any complications resulting in the morbidity or mortality of a mother or a neonate; and
(10) Any other information required by the Board in regulations.

Pursuant to Health Occ. § 8-6C-12(a)(10), below please find the Committee's summary of the above-listed information that was provided by DEMs in the Data Collection Forms received by the Committee. This data is for the period from July 1, 2021, to June 30, 2022, fiscal year (FY) 2022. During the reporting period, there were 34 DEMs licensed to practice in Maryland.

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

Total Number: 737[2]

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

Total Number: 453

Allegany County	5	Harford County	26
Anne Arundel County	13	Howard County	12
Baltimore City	31	Kent County	0
Baltimore County	46	Montgomery County	32[3]
Calvert County	11	Prince George's County	48
Caroline County	5	Queen Anne's County	3
Carroll County	17	St. Mary's County	64
Cecil County	32	Somerset County	2
Charles County	20	Talbot County	1
Dorchester County	1	Washington County	25
Frederick County	44	Wicomico County	9

[1] The Data Collection Form notes: "For purposes of completion of this Form, "Onset of Care" means any initial intake or care of a client during pregnancy, regardless of when in the pregnancy, or the outcome of the pregnancy."

[2] Out of the 34 Data Collection Forms that the Committee received and reviewed, three DEMs did not complete this question. Two of the three DEMs did, however, complete Question #2, indicating a number of live births attended as primary caregiver in one or more of Maryland's counties. (One documented that 15 live births were attended, and one documented that 8 live births were attended.) In light of this, the Committee believes that the total number of clients served as primary caregiver at onset of care may be higher than what is reflected in the answer to Question #1.

The Committee further notes that one written answer was not clearly legible but appears to be the number three. The Committee has included this answer (3) in the total number for Question #1. The Committee will consider requiring that the answers to the Data Collection Form be typed in the future.

[3] The Committee notes that one Data Collection Form was not clearly legible with respect to Question #2, specifically how many live births were attended as primary caregiver in Montgomery County. The answer appears to be either the number 0 or the number 6. The Committee has treated this answer as a 0. As noted in footnote #2, the Committee will consider requiring that the answers to the Data Collection Form be typed in the future.

Garrett County	1	Worcester County	4

(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

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	1	Prince George's County	0
Caroline County	0	Queen Anne's County	0
Carroll County	0	St. Mary's County	0
Cecil County	0	Somerset County	0
Charles County	0	Talbot County	0
Dorchester County	0	Washington County	0
Frederick County	0	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:[4]

Total Number: 94[5]

Code	Reason for Transfer	Total Number of Transfers
301	Medical or mental health conditions *unrelated* to pregnancy	2
302	Hypertension developed in pregnancy	8[6]
304	Anemia	1
307	Gestational diabetes	1
308	Vaginal bleeding	1
309	Suspected or known placental anomalies or implantation abnormalities	3
310	Loss of pregnancy (includes spontaneous and elective abortion) *when a transfer took place*	6

[4] The Data Collection Form notes: "For each transfer, please choose one (1) **primary** reason for transfer."

[5] One DEM documented a total of four transfers but then listed five transfers for specific reasons. The Committee only has included four in the total number.

[6] In response to Question #9, a DEM who documented one transfer for Code 302 provided more information about the transfer, but the Committee cannot disclose that answer pursuant to Health Occ. § 8-6C-12(b), which prohibits the Committee from including any personally identifying information in this Report.

313	Fetal anomalies	3
316	Non vertex lie at term	3
317	Multiple gestation	1
318	Clinical judgement of the midwife (when a single other preceding condition listed on the Data Collection Form does not apply)	9
319	Client choice/non-medical [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, etc.]	26
320	Other: S*pecified by DEM as follows*:	
	"Covid-related"	1
	"Post 42-weeks"	1
	"Client requested induction"	1
	"Post dates – 42 weeks"	1
	"Client had unrealistic expectations of home birth"	1
	"Induction/post dates"	1
	"Transferred to another provider due to . . . [7]"	22
	"BMI 735"	1
	"Fibroid"	1
	"Thick mec on US"	1

(5) The number, reason for, and outcome of each nonemergency hospital transfer during the intrapartum or postpartum period:[8]

Total Number: 58[9]

Reasons for Transfer (and number of transfers for this reason)	Outcomes for pregnant/birthing client if available (and number of clients with this outcome)	Outcomes for infants, if available (and number of infants with this outcome)
Reason for intrapartum elective or nonemergency transfers		
501: Persistent hypertension, severe or persistent headache (1)	101: Healthy client, no serious pregnancy/birth related medical complications (1)	No infant outcome provided (1)

[7] One DEM documented transferring 22 clients under Code 320. The Committee cannot disclose the full reason for the transfer that the DEM provided pursuant to Health Occ. § 8-6C-12(b), which prohibits the Committee from including any personally identifying information in this Report.

[8] The Data Collection Form notes: "For each transfer, please choose one (1) **primary** reason for transfer."

[9] Out of the 34 Data Collection Forms that the Committee received and reviewed, one DEM answered "0" but documented three reasons for transfer. Therefore, the Committee included three in the total number, to include the three reasons for transfer listed.

504: Signs of infection (1)	101 (1)	201: Healthy live born infant (1)
505: Prolonged rupture of membranes (4)	101 (3)	201 (3)
506: Lack of progress, client exhaustion, dehydration (22)	101 (23)	201 (18) No infant outcome provided (5)
507: Thick meconium in the absence of fetal distress (2)	101 (2)	No infant outcome provided (2)
508: Non-vertex presentation (2)	101 (2)	201 (2)
509: Unstable lie or malposition of the vertex (3)	101 (3)	201 (3)
511: Clinical judgment of the midwife (when a single other preceding condition listed on Data Collection Form does not apply) (6)	101 (5) 102: With serious pregnancy/birth related medical complications resolved by 6 weeks (1)	201 (4) No infant outcome provided (2)
512: Client request; request for methods of pain relief (9)	101 (9)	201 (8) No infant outcome provided (1)
513: Other (1)	101 (1)	201 (1)
Reasons for postpartum pregnant/birthing client elective or non-emergency transfers		
702: Repair of laceration beyond midwife's expertise (5)	101 (5)	201 (3) 207: Unknown (1) No infant outcome provided (1)
Reasons for nonemergency infant transfers		
904: Poor transition to extrauterine life (1)	No client outcome provided (1)	201 (1)
907: Clinical judgment of the midwife (when a single other condition listed on the Data Collection Form does not apply) (1)	No client outcome provided (1)	202: With serious pregnancy/birth related medical complications resolved by 3 weeks (1)

(6) The number, reason for, and outcome of each urgent or emergency transport of an expectant mother in the antepartum period: [10]

Total Number: 7

[10] The Data Collection Form notes: "For each transfer, please choose one (1) **primary** reason for transfer."

Reasons for Transfer (and number of transfers for this reason)	Outcomes for pregnant/birthing client if available (and number of clients 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 (3)	101: Healthy mother, no serious pregnancy/birth related medical complications (3)	201: Healthy live born infant (3)
406: Preterm labor or preterm rupture of membranes (4)	101 (4)	201 (2) 202: With serious pregnancy/birth related medical complications resolved by 4 weeks (1) 206: Live born infant who subsequently died (1)

(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:[11]

Total Number: 22

Reasons for Transfer (and number of transfers for this reason)	Outcomes for pregnant/birthing client if available (and number of clients with this outcome)	Outcomes for infants, if available (and number of infants with this outcome)
Reasons for urgent or emergency intrapartum transfers		
606: Non-reassuring fetal heart tones and/or signs or symptoms of fetal distress (4)	101: Healthy mother, no serious pregnancy/birth related medical complications (4)	201: Healthy live born infant (4)
608: Other life-threatening conditions or symptoms (1)[12]	101 (1)	201 (1)
406:[13] Preterm labor or preterm rupture of membranes (1)	101 (1)	201(1)
Reasons for immediate postpartum maternal urgent or emergency transfers		

[11] The Data Collection Form notes: "For each transfer, please choose one (1) **primary** reason for transfer."

[12] The DEM who reported one transfer for Code 608 further provided: "cord aulsion."

[13] Code 406 is a code for Question #6 (for reasons for urgent or emergency antepartum transfer), but a DEM used this code when answering Question #7.

803: Uncontrolled hemorrhage (5)	101 (3) 102: With serious pregnancy/birth-related medical complications resolved by 6 weeks (2)	201 (5)
805: Adherent or retained placenta with significant bleeding (2)	101 (2)	201 (2)
808: Clinical judgment of the midwife (when a single other preceding condition listed in the Data Collection Form does not apply) (1)	101 (1)	201 (1)
Reasons for urgent or emergency infant transfers		
351: Abnormal vital signs or color, poor tone, lethargy, no interest in nursing (3)	101 (3)	201 (3)
359: Significant cardiac or respiratory issues (3)	101 (2) No client outcome provided (1)	201 (2) 103: With serious pregnancy/birth related medical complications not resolved by 6 weeks[14] (1)
360: APGAR of less than seven at 5 minutes (1)	101 (1)	201 (1)
363: Other (1)	101 (1)	203: With serious pregnancy/birth related medical complications not resolved by 4 weeks (1)

(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): 482

Total number completed in an out-of-hospital setting (*i.e.*, completed at home/birth center as planned): 428

Total number of clients who have not yet given birth as of June 30th: 192

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

[14] Code 103 is a code for client outcome, not infant outcome, but was used by one DEM when answering this question.

Regarding the infant outcome code of 206 in response to Question #6, the DEM wrote:

> Mother in preterm labor transferred to a level 2 facility. Labor stopped but baby diagnosed with LUTO: lower urinary tract obstruction. Mother then transferred to a high tertiary care facility where a live born baby was delivered who was then transferred to Children's Hospital where [the baby] died from complications of LUTO.

II. Committee's Recommendations

The Committee hereby provides the Board with the following information to assist the Board with providing additional information[15] 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:

The Committee makes the same recommendations made for FY 2021, which were as follows:

> 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

[15] 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).

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:

The Committee makes the same recommendations made for FY 2021, which were as follows:

> 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, 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 licensed DEMS and the Committee so that the Board can compile its required report to the Maryland General Assembly by December 1, 2022.