SB 376_PJC_Favorable_FIN.pdf
Uploaded by: Ashley Black
Position: FAV

Ashley Black, Staff Attorney
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SB 376
Health Occupations – Licensed Direct-Entry-Midwives – Previous Cesarean Section
Hearing of the Senate Finance Committee
February 28, 2023
1:00 PM

SUPPORT

The Public Justice Center (PJC) is a not-for-profit civil rights and anti-poverty legal services organization which seeks to advance social justice, economic and racial equity, and fundamental human rights in Maryland. Our Health and Benefits Equity Project advocates to protect and expand access to healthcare and safety net services for Marylanders struggling to make ends meet. We support policies and practices that are designed to eliminate economic and racial inequities and enable every Marylander to attain their highest level of health. **The PJC stands in strong support of SB 376**, which would allow a licensed direct-entry midwife to assume or take responsibility for a client who had a previous cesarean section. It also requires the Maryland Board of Nursing, in consultation with the Maryland Institute for Emergency Medical Services Systems and other specified stakeholders to develop a standard planned out-of-hospital birth transport protocol for patients who meet the criteria.

PJC supports the right of patients to make informed decisions about the maternal health options that are best for them and their family. However, Maryland law prevents women who have had a previous cesarean section (c-section) from accessing home birth providers. This birthing prohibition creates a disparity in access between women who have never had a c-section and the 33.7% of women in Maryland who have had a c-section.[1] This gap is even greater for Black women in Maryland compared to their White counterparts as c-section delivery rates were highest for Black women at 38.9% in 2020.[2] Similarly, women in rural counties, including Somerset which is a maternity care desert[3], have even less access to certain maternity care providers and birthing options.

[1] Maryland Department of Health, *Maryland Vital Statistics Annual Report* (2020), https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Annual%20Reports/2020Annual.pdf.

[2] *Id.*

[3] March of Dimes, *Nowhere to Go: Maternity Care Deserts Across the U.S.* (2022), https://www.marchofdimes.org/maternity-care-deserts-report.

The Public Justice Center is a 501(c)(3) charitable organization and as such does not endorse or oppose any political party or candidate for elected office.

SB 376 would expand birthing options for pregnant women in Maryland who choose to pursue a vaginal birth after cesarean (VBAC) from a licensed direct-entry midwife. Opening access to VBAC as an option for women promotes positive health outcomes, including less blood loss, shorter recovery times, and lower risk for infection and other complications. SB 376 is consistent with Maryland's mission to improve health equity and healthcare access for women, including women of color and women residing in rural areas. This legislation also supports informed decision making and would allow women who want to have the experience of a vaginal delivery the option to do so.

For these reasons, the Public Justice Center urges the committee to issue a **FAVORABLE** report for **SB 376** to promote access to patient-centered maternal health care and health equity**.** If you have any questions about this testimony, please contact Ashley Black at 410-625-9409 x 224 or blacka@publicjustice.org.

The Public Justice Center is a 501(c)(3) charitable organization and as such does not endorse or oppose any political party or candidate for elected office.

Letter in support of SB376 - Shifrah's Sisters Mid
Uploaded by: Caitlin McDonough
Position: FAV

Shifrah's Sisters
HOLISTIC BIRTH SERVICES

28 February 2023

Elizabeth Reiner
4705 Ford Fields Road
Myersville, MD 21773

To Chair Griffith and Members of the Senate Finance Committee,

Thank you very much for all of the work that you do for our state!

My name is Elizabeth Reiner and I am a home birth mother, Certified Professional Midwife, Licensed Direct Entry Midwife, Secretary of the Association of Independent Midwives of Maryland (AIMM), and former Vice-Chair of the Maryland Direct Entry Midwifery Advisory Committee. I have been attending births for 20 years and have been a CPM for 11 years.

I am writing in support of SB376.

As a licensed midwife, I already attend home vaginal births after cesareans (VBAC/HBAC) in all of our surrounding states—VA, PA, WV and DC—where VBAC *is* permitted. VBAC is well within the scope of practice for CPMs, especially with the restrictions that our current statute/regulations and this bill create. Additionally, our Certified Nurse Midwife (CNM) colleagues currently attend HBACs in Maryland, which means that our state already has a precedence for midwives attending VBACs outside of the hospital setting. Sadly, however, there are not enough CNM home birth practices to meet the vast need throughout our state—which means many of these parents who want to bring their children into the world in their own homes after having a cesarean birth cannot find a supportive provider to do so or need to travel to our neighbor states. Especially given the current strains on our healthcare system, we need every qualified and licensed provider on deck to serve our Maryland birthing families!

LDEMs can meet this need and fill this void: We are trained in this precise birthing scenario.
It's also important to know that VBAC families are often extremely well-informed, -educated and -aware of the risks and benefits of the birth they desire. They choose our care with the utmost intention, and we take their trust very seriously.

Shifrah's Sisters
HOLISTIC BIRTH SERVICES

One of the main concerns and arguments against HBAC is that uterine rupture may occur. The statistical reality: This occurs in a range of 0.4 to 0.9% of all VBACs, even the higher risk ones that this bill already excludes. It is not because VBACs are without risk that it is a reasonable choice to have an HBAC. It is that *all* birth comes with inherent risks, including the very dangerous risks that accompany the high rates of repeat cesarean surgeries in our Maryland hospitals--placenta problems (accreta and percreta), hemorrhage, infection, scar tissue adhesions, damage to other organs, hysterectomy, and more.

Informed consent and patient autonomy means that the birthing family gets to choose the set of risks that they are most comfortable with. Plus, rupture can happen in any stage of labor, including earlier in labor where even a family planning a hospital birth has not yet arrived in the hospital. For my clients' HBAC births, I arrive to the labor earlier in the process than I do with non-VBAC clients. I am even more vigilant than usual and monitor even more closely than usual.

It is wonderful when families can find a supportive OB/GYNs to support them for a hospital VBAC but unfortunately, that level of support is not accessible to most birthing families throughout Maryland, as is reflected in our 16.3% hospital VBAC success rate. Most especially not within communities of color and rural populations. Typically home birth midwives have an 85% and higher success rate. I am personally happy to answer any questions about LDEMs, AIMM or HBACs that I can.

Thank you for your support of this small but impactful bill!

Sincerely,

Elizabeth S.K. Reiner

Elizabeth Reiner, CPM, LDEM, LM

202.446.4400 | *elizabeth@shifrahssisters.com* | shifrahssisters.com

SB376 - Direct-entry midwife bill support - Patric

Uploaded by: Caitlin McDonough

Position: FAV

February 28, 2023

Testimony in Support – Senate Bill 376 – Health Occupations – Licensed Direct-Entry Midwives – Previous Cesarean Section

Dear Chair Griffith and Members of the Committee:

I am writing to offer my enthusiastic support for HB376. This common-sense legislation will expand reproductive rights, which are surprisingly limited when it comes to childbirth in our state. While Maryland is among the more progressive states in terms of a woman's ability to choose *whether* to deliver a child, Maryland is among the more regressive when it comes to a woman's ability to choose *how, where,* and *with whom* she delivers her child.

Current Maryland law allows all midwives to attend home births, but only allows Certified Nurse Midwives (CNMs) to attend home births for clients seeking a vaginal birth after cesarian (VBAC). What does mean from a practical perspective? By way of example, a low-risk expecting mother who resides in Baltimore City and wants to have a VBAC is limited to the following options outside a hospital setting:

> Option A – Choose between a grand total of three (3) CNMs in the entire state of Maryland that attend home births in the Baltimore metro area and hope she can get on their books before their high-demand schedules fill up.
>
> Option B – Travel out of state to deliver at a birthing center, as there are currently no birthing centers operating in the entire state of Maryland.
>
> Option C – Attend her own home birth unassisted, which is legal in all 50 states.

While midwives have an excellent home-birth VBAC success rate (80-90%), access to a home-birth VBAC is extremely limited under current Maryland law. Traveling out of state or attending one's own birth are often not practical or desirable. As a result of the lack of real choice and access, most women pursuing a VBAC end up delivering in a hospital setting, where they have a roughly 15% chance of having a VBAC versus an 85% chance of having a repeat cesarean, which involves significant blood loss and carries the risk of complications with delivery, nursing, recovery, and future pregnancies. Unfortunately, hospital births also pose a higher risk of trauma and maternal mortality - particularly among the BIPOC community, which has long been subject to systemic racism in hospitals. The COVID-19 pandemic also showed us how keeping low-risk patients out of the hospital can reduce the strain on our health care system, and the demand for home birth is rising.

This bill gives women who want a VBAC an Option D – the choice to pursue a trial of labor at home under the care of a direct-entry midwife, with more than sufficient safety protocols in place. This is a choice that my own wife, despite being the textbook definition of low-risk, is not currently afforded by our state government - purely because our first child was born via a cesarian section. I humbly ask that you trust women to make their own informed decisions about their bodies, and who they wish to attend their births, by passing this legislation.

Thank you for your consideration,

Patrick Terranova

SB376 - Jessica Watts - Testimony.pdf
Uploaded by: Caitlin McDonough
Position: FAV

February 28, 2023

Greetings Chair Griffith and Members of the Committee,

My name is Jessica Watts, and I am writing in favor of SB376.

After my first pregnancy ended in a cesarean, I was forced to fight long and hard to find a supportive VBAC provider for my second and third pregnancies. In the end, I wasn't successful, and at every step I felt stripped of my personal autonomy.

My difficult journey lead me to midwifery school — to help those who find themselves unseen and unheard. I'm writing to you today, because Certified Professional Midwives (CPMs) having the ability to attend VBACs are precisely what our community needs.

Our state's current cesarean rate is among the highest in the country — over 30% of births in MD end up in an operating room. The World Health Organization states that the number of cesareans should not exceed 10-15%.

While those numbers are staggering, what's worse is the lack of support for birthing people who seek a Vaginal Birth After Cesarean (VBAC) - in several Maryland counties there isn't a single provider who will attend a VBAC.

I ask for your support of SB376 so that those that desire a VBAC have access to safe, supportive care.

Thank you for your time.

Kindly,

Jessica Watts

Jessica Watts
713 Anneslie Rd Baltimore MD 21212

Jessica Watts
713 Anneslie Rd Baltimore MD 21212

SB376 - LDEM Letter of Support - Brittany Coffman.
Uploaded by: Caitlin McDonough
Position: FAV

Brittany Coffman
3376 Sumantown Road
Middletown, MD 21769

The Honorable Melony Griffith
Chair, Senate Finance Committee
Miller Senate Office Building, 3 East
11 Bladen Street
Annapolis, MD 21401

February 28, 2023

Testimony in Support
Senate Bill 376 – Health Occupations – Licensed Direct-Entry Midwives – Previous Cesarean Section

Dear Chair Griffith and Members of the Committee:

My name is Brittany Coffman and I'm a Maryland licensed Direct Entry Midwife as well as a Maryland Board Certified Physician Assistant. I support families choosing home birth in Frederick County, and I'm so grateful to be able to provide this service to the community in which I live. As a practitioner who has worked in hospitals, clinics, in surgery, family practice, speciality, and now in the homebirth community; I can tell you that the level of care and attention that homebirth midwives provide is exemplary.

As midwives who specialize in low risk, healthy clients, we are able to help hospitals prioritize higher need patients. This is especially important in the last few years, when the pandemic has stretched our medical system thin. Our hospital providers are doing such important work, but within our scope of practice there is a definitely lacking in our legislation to include clients who have had a previous cesarean birth.

The chance of uterine rupture with a low-transverse or bikini-cut incision is anywhere from 0.2% to 1.4%. We can reduce risks by proper evaluation and management. Repeat cesareans come with serious risks. Please help us keep this portion of our community low risk and thriving!

Warmly,
Brittany Coffman

SB376 - Letter of Support - Nathan and Esther Gray

Uploaded by: Caitlin McDonough

Position: FAV

Testimony in Support – Senate Bill 376 – Health Occupations – Licensed Direct-Entry Midwives – Previous Cesarean Section

Dear Chair Griffith and Members of the Committee,

We are writing today in favor of SB376.

In 2012 we were blessed with our first child. Our son was delivered by cesarean section after 24 hours of unsuccessful labor. It was an unpleasant experience to say the least.

In 2014, 8 months into pregnancy with our second child, our doctor told us that we would need to schedule a cesarean section, after he had already assured us earlier on that a TOLAC would be fine.

We scrambled to find a doctor that would stick to the original plan. We found a doctor and our second son was born vaginally after a successful TOLAC. It was flawless.

In the following few years we were blessed with a 3rd boy and a little girl who were also delivered via smooth and super successful VBAC births, despite the seemingly increasing discomforts associated with hospital births and procedures.

When we found out we were having our 5th child we decided to have a home birth. We thought it would be more comfortable and take a lot of stress out of the process for us.

We found a midwife that we were absolutely comfortable with, only to find out that she could not help us because our first son was born of cesarean section and the midwife we found and loved was a CPM and not a CNM. This law made no sense to us, especially since all the midwives we spoke to whether they were a CNM or CPM seemed equally as knowledgeable and qualified in the field.

We ended up finding a suitable CNM who we were comfortable with as a second choice and our 2nd daughter was born in the comfort of our home without any issues at all.

There is no reason we should not be able to choose the Midwife we are most comfortable with in the future.

Please support Maryland families and vote yes on SB376.

Sincerely,
Nathan and Esther Grayman
3913 Labyrinth Rd,
Baltimore, MD 21215
410-905-8047

SB376 - OHora Testimony - Support.pdf
Uploaded by: Caitlin McDonough
Position: FAV

WELLNESS & Co.

Tuesday, February 28, 2023

Dear Chair Griffith and Members of the Committee,

I am speaking in favor of SB376. This written testimony speaks to my personal and professional perspective regarding the importance of women being able to access and work with Licensed Direct Entry midwives for their VBAC care.

> *"It feels so redemptive" - that's what I said after birthing my second son via VBAC in the comfort of my home this past New Years Eve.*
>
> *In 2021, while pregnant with my first child, I was working with one of Maryland's Licensed Direct Entry midwives. In the last weeks of my pregnancy with my baby in the breech presentation, my midwife was forced to terminate my care under Marylands regulations.*
>
> *Unable to find another provider local to me, I was forced to travel to a neighboring state. After laboring 24 hours and a baby who wouldn't drop, the birth center and I chose to transfer to a hospital for more choices.*
>
> *As a result, I had to have what was deemed as an "emergency c/s" (even though me and Baby were fine by all measures). At the hospital my written birth plan was not respected and my husband experienced extensive secondary birth trauma.*
>
> *But I'm not just a mom who finally got her VBAC, I'm also Dr. Kendra O'Hora, a Licensed Clinical Marriage and Family Therapist and owner of a mental health practice in Harford County where I employee nine providers, two of which are perinatal mental health specialists working extensively with birth trauma.*
>
> *Through my own two birth experiences in the last 16 months, through supervising my team, and through working clinically with women on their postpartum journey - I've seen firsthand the gaps in care in Maryland.*
>
> *SB376 is not just a lofty bill, it's necessary. I could go on and on about the statistics of the mental health prevention associated with women getting to choose their care team and birthing in the way that best suits them. And, that data is important.*
>
> *More important is that I remind you how I started this testimony, the words I spoke after vaginally delivering my second baby: "it feels so redemptive."*
>
> *I'm here - physically healthy, mentally well, and so so strong because I got my VBAC.*

It's time that my Licensed Direct Entry Midwife be able to deliver my next baby and that women all over Maryland be supported in their birth wishes of having a VBAC by these competent and professional care providers.

My hope is that the written and spoken words of these professionals and the personal testimonies of mothers will provide each member of the committee with a balanced internal response. I once heard that good legislation is clear and simple. Supporting SB376 is both logical and makes emotional and intuitive sense. I compel your agreement.

Thank you for your time.

Sincerely,
Kendra A. O'Hora, PhD, Licensed Clinical Marriage and Family Therapist

SB376 - SBON LDEM Annual Report 2022.pdf
Uploaded by: Caitlin McDonough
Position: FAV

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

Maryland
DEPARTMENT OF HEALTH

Board of Nursing

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

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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Fax: (410) 358 - 3530
www.mbon.maryland.gov

(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.

SB376 - SUPPORT - Charm City Midwives.pdf
Uploaded by: Caitlin McDonough
Position: FAV

The Honorable Melony Griffith
Chair, Senate Finance Committee
Miller Senate Office Building, 3 East
11 Bladen Street
Annapolis, MD 21401

February 28, 2023

Re: Senate Bill 376 - Health Occupations - Licensed Direct-Entry Midwives - Previous Cesarean Section

Position: Support

I have been a Certified Nurse-Midwife for 15 years and prior to that a Labor and Delivery nurse. I have worked in 3 Baltimore-Washington area hospitals. As a midwife, I attended births in hospital settings for 8 years prior to opening my homebirth practice. When I started attending homebirths, I was blown away, but honestly not surprised, by the number of women choosing homebirth due to traumatic experiences with their last birth. They felt they had no choice and were coerced into making decisions for unnecessary interventions. Many of my current VBAC clients are black women who honestly don't know why they had their first c-section. They say they were young and didn't know any better and when the doctor told them they would be better off with a c-section, they acquiesced. Now that they're older and more educated, they regret having a c-section, which now limits their option for vaginal birth and was likely unnecessary to begin with.

I have clients calling me in Baltimore from the Eastern Shore and southern Maryland because they can't find an OB provider that is willing to offer them a trial of labor. Many hospitals in those areas are not allowing VBACs as policy. There are very limited or no CNMs in those areas who are offering home VBACs.

As we know, and my clients also know, the risks of a repeat c-section are significant. Especially when a client wants to have a large family, there are only so many c-sections that are considered safe. There is the risk of injury to adjacent organs, hemorrhage, infection, injury to the baby, and prolonged hospital stay. There are the long term sequelae including pain, adhesions, scar tissue, and muscle disruption. Many turn to homebirth as they don't have a satisfactory hospital option, especially in rural communities.

The options for VBAC in Maryland are inadequate. Licensed Direct-Entry Midwives are well trained and qualified to offer homebirth to women who have had a prior c-section in a safe and comfortable environment. There are not enough CNMs or even hospital providers to care for all these clients. Due to COVID, an increasing number of pregnant people are choosing to birth at home instead of risking infection and the inability to have multiple support people with them in the hospital. I am regularly turning away inquiries from my busy practice. We need more options for childbirth in Maryland, especially VBAC. LDEMs are qualified and needed to fill this need in our community.

I appreciate your consideration of this matter. Please support Senate Bill 376.

Respectfully,
Bayla Berkowitz, CNM, MSN

Charm City Midwives
16 Sudbrook Ln
Pikesville, MD 21208
Phone 443.4BIRTH6 (424.7846)
Fax 443.817.0491
www.charmcitymidwives.com

SB376 - Support - Christina Andrews.pdf
Uploaded by: Caitlin McDonough
Position: FAV

The Honorable Melony Griffith
Chair, Senate Finance Committee
Miller Senate Office Building, 3 East
11 Bladen Street
Annapolis, MD 21401

February 28, 2023

TESTIMONY IN SUPPORT: Senate Bill 376 – Health Occupations – Licensed Direct-Entry Midwives – Previous Cesarean Section

Dear Chair Griffith and Members of the Committee:

It has been my joy to serve as a doula in Maryland for many years. I have helped women birth in hospitals and at home. All kinds of women in all types of families. One of the common challenges I have heard through my 25 years as a doula is the fear of having a cesarean and the inability after a cesarean for families to choose a birth location and space that is appropriate for them.

Over the last 10 years, in particular, the women that I have worked with have felt like their hands were tied when thinking about birth after a previous cesarean. This is especially true when a family wants to work with a midwife and have a homebirth. Though they may have worked with the midwife in 2, 3, or 4 previous births to have successful births aligned with their values and desires, after a cesarean, it is an option that is barred for them. Midwives have the training and knowledge to evaluate birth and make decisions, in collaboration with the family about if a transfer is necessary. They open birth to families of color that would not be monitored as closely in the hospital environment and give them additional supports.

Maryland should adopt the same legislation as other States that allows midwives to provide care to families seeking VBACS.

Sincerely,

Christina Andrews

SB376 - Support - Marvi Milagros .pdf
Uploaded by: Caitlin McDonough
Position: FAV

Marvi Rivera
1010 Timber Creek Dr, Annapolis, MD 21403
954-263-7275

The Honorable Melony Griffith
Chair, Senate Finance Committee
Miller Senate Office Building, 3 East
11 Bladen Street
Annapolis, MD 21401

Dear Chair Griffith and Members of the Committee:

I am writing you in support of SB0376.

What I am about to share is lengthy, but it has been the most traumatic set of events in my life and I believe there is value in sharing it to provide perspective on the positive impact of the aforementioned bill.

In April of last year, I was 16wks pregnant and went to my local hospital three times in a matter of 12 days with persistent high fevers and debilitating abdominal pain. I was sent home every time. In those 12 days, I experienced an ER technician blowing his breath on my arm prior to collecting blood cultures, a pelvic exam with water from the sink due to the lack of gel in the room, and a thermometer set for rectal temperature placed in my mouth with no protective cover.

On April 27th, at 19 wks, I went in for a follow up appointment with my OB and I was told my baby didn't have a heartbeat. They gave me time to call my partner and then coldly gave me a paper map so I could find Labor & Delivery (L&D). I left the office in shock. I called my family, inconsolable, while driving around frantically trying to find the Labor & Delivery area of the hospital. Once at L&D, I was sent to a room where I waited for doctors to confirm the lack of heartbeat. They admittedly forgot about me and didn't know I was waiting on them to take the appropriate next steps. I was sent to Maternal Fetal Medicine (MFM) for an amniocentesis and the OBs at L&D told me they would give them a heads up that I was on my way. When I got to the MFM, the receptionist had no idea why I was there, so I had to re-explain my already painful details to her in the lobby with other patients. Once done with the MFM, I went home to pack a hospital bag.

When I arrived at the hospital the OB induced me and I elected to have an epidural. The emotional pain of losing the baby was already enough for me, so I opted to at least numb half of my body. A half hour after the epidural, the very apologetic anesthesiologist came to remove it because they had JUST found out I had an infection that had spread to my blood. I had sepsis. Now, as a traumatized first-time mom, and having had no time to prepare myself for a trial of labor, I had no idea what to expect. The nurses just told me to be careful when I went to the bathroom. The pains that I figured were contractions, started. Before I could even make sense of the timing and pain, I birthed my little Andres. The nurses came in to check on me and took the baby to wrap him in cute hospital garments. We decided we wanted time to hold him and after a couple of days, we told several staff members that we wanted to cremate him at a specific funeral home. What followed was an unbelievable chain of "drop the ball" moments, on top of the already painful loss of my baby.

Since I had to stay in the hospital due to the infection, I decided to shower at some point. Stepping out of the shower, my foot slipped, I fell and hit my head. I later read the nurse's report, she stated that I went to the toilet, tripped on a towel, jumped in the shower and refused care. Not what happened and both my mother and my partner can confirm.

After being allowed to leave the hospital on May 1st, I had to call 911 on May 2nd, because my fever returned. I waited in line with my two EMTs for 3+ hours before they could get me in a room. In the meantime, I called my OB's emergency line and the doctor hung up on me twice for reasons I still do not understand. My mom was finally allowed to join me at 11pm and she stayed with me until the hospital staff kicked her out at 6am because I was being admitted and the hospital did not allow visitors until 9am. By this point, I did not have the strength to make sense or argue this, so I told my mom to return during "visiting" hours. Looking back, she was not a visitor, she was my support person during a time where I needed the most support. The hospital staff transported me through the basement of the hospital to my

new room at the very end of the Mother/Baby wing. I was left in that room for what felt like hours, until nurses and doctors came in to introduce themselves around 8am. This time, they told me I needed a doctor's order to shower...maybe they forgot to share during my last stay at the hospital. A couple of days later, my IV line became occluded and they offered to set up another one. Three people tried to set up the line, each poking me and fishing for a vein three times. I still have flashbacks of that agonizing pain. Finally, someone offered up IV therapy and I quickly realized the physical abuse and trauma I had just endured was based solely on the fact that nobody wanted to call this genius technician with a clear visual map of where my vein was located.

Once I finally left the hospital, I went to the funeral home on May 9th to ensure they had everything they needed. Funeral home told me the hospital never did anything to release my son...so he had been sitting there since April 27th so nobody did anything with the information we gave them while I was being treated.

On May 25th, I went in for my postpartum appointment, and the nurse checking me in asked if I was breastfeeding. Insult to injury. Any hope I had to stay with this practice, quickly dissipated upon hearing those words. Clearly, she forgot to read in my chart that dead babies don't need milk.

As a result of medical advice stemming from these general events, I underwent laparoscopic myomectomy on July 27th at a different hospital and I am now stuck with a blind recommendation for a c-section at 37 weeks for future pregnancies. This is why I am asking you to consider doing all you can to ensure this bill is approved. Women and mothers like me deserve the opportunity to have individualized care in an environment where they feel safe, heard and supported. I recognize that place is not the same for everyone. I can only speak for myself (and advocate for others) and I would love to have the option to birth my children with the support of midwifery care, away from the sometimes-obtuse medical model and away from the self-preserving hospital protocols.

I come from a family of service: my mother is a nurse that retired from the VA hospital, my father was a police officer in Puerto Rico, my soon-to-be husband is a police officer in Maryland, and I am a proud Coast Guard service member. I value your service and appreciate your support in an effort to continue expanding midwifery care. Please let me (and others like me) have a chance at experiencing birth on our terms, with our informed choices, and with the individualized care and empathetic & confident support of the midwifery model.

Thank you for taking the time to learn about my story and thank you for supporting this initiative.

Very respectfully,

Marvi Milagros Rivera

MFSB testimony (1).pdf
Uploaded by: Colleen Good
Position: FAV

I am Colleen Good from Harford County. I am a mom of two and I write this in favor of Senate Bill 376.

When I got pregnant with my daughter almost three years ago, I began seeing a team of nurse midwives and OBGYNs at the hospital I worked at and prepared for the daunting event that is childbirth. I was blessed with an uneventful pregnancy. I longed for an unmedicated birth and expressed this to my medical team, who seemed indifferent to my desires. All my prenatal care lacked informed consent. It was assumed I would consent to every test and exam without much education on the reasons for intervention, such as cervical checks and bloodwork. I barely got fifteen minutes with my provider, so they quickly answered and dismissed my questions to move through the appointment. I was two days past my due date when my provider expressed concerns about my pregnancy extending much further. With a perfect heartbeat on my baby girl, no blood pressure concerns for me, I was shocked. I was able to argue my way into holding off my induction until 41 weeks and 1 day with some extra monitoring. I enter the hospital for my induction extremely nervous regarding what is ahead of me, as I was uninformed that the provider scheduled that evening was one I had never met before. Settled in my hospital bed, this provider walks in without introducing herself, puts gloves on, and lubes her fingers to check my cervix. This invasive exam was performed by someone who did not even tell me her name, nor explained what she was doing. I paced most of the night unable to sleep, even though I was not having contractions yet. They later started me on Pitocin, a medication to induce contractions. Despite my desire to avoid an epidural, the nurse continued to increase the dose on the medication until my contractions were giving me no time to rest in between. After hours of working through them I gave in and got an epidural. When time to push, I pushed for four hours. Thankfully, I was able to deliver her vaginally as she tolerated the long pushing period. My daughter cried perfectly and required no interventions once born. We adjusted to our new baby while barely sleeping between trying to feed her and being interrupted almost hourly in our hospital room. We started off our postpartum period emotionally exhausted from the long process at the hospital and physically tired from the poor rest we got before discharging home. Postpartum was difficult emotionally and physically, and I doubted for months whether to have another child.

Early in 2021, my husband and I were expecting again. We both agreed we could not go through the process we went through in the hospital unless necessary. I began my search for a home birth midwife, which led me to Deanna Kopf. She assured me at our first visit that she believed in a “hands off” approach during labor, meaning no interventions, unless medically necessary or requested by the mother. Each prenatal visit was 45 minutes to an hour long, where we discussed my diet, physical activity, and emotional health. Before examining my stomach, they always asked if they could touch me. I was educated on every test offered to me before consenting, so I could make informed decisions for me and my unborn son. Never once was there a discussion for inducing me, as both my baby and I remained healthy. I naturally went into labor eight days after my due date. I was able to sleep in my own bed for a few hours before contractions intensified. I listened to music in my bedroom and breathed through the contractions. Deanna and her student came to my home and asked to check my vital signs and check baby’s heartbeat. Once they were finished I was left to labor with my husband, as they set up their emergency supplies and watched me from a distance. My body naturally began to push, so I got in the birth tub as soon as possible. I was never told to labor or push in a certain position, so I did what my body felt it needed to do. My son was born without any issues, he breathed perfectly and cuddled quietly with me. After delivery, we were able to rest in our bed to work on breastfeeding. Deanna and

her student monitored vital signs for me and my baby and watched my bleeding, before leaving us to rest. We napped and ate in bed as we recovered and adjusted to this new life. Postpartum has been a completely different experience for me physically and emotionally this time around, and I credit that to the amazing care I received from Deanna and her team and the beautiful experience I was blessed with.

If my first birth had ended in a c-section, I would not have been able to give birth to my son at home. Despite the statistics showing how safe a VBAC can be, many women are deterred from vaginal birth in hospitals after a prior c-section. By giving direct-entry midwives the ability to work with these women with a prior c-section, it gives women a choice where and how they want to birth their babies. It gives women prenatal care beyond quick, impersonal appointments. The prenatal care offered by these midwives is empowering, as they encourage women to care for themselves physically and emotionally and allow them to trust their bodies during this natural process. Midwifery care allows informed consent. Many women do not need, nor do they want interventions during their labor and birth. Bill 376 allows women a choice when choosing prenatal care, despite a prior c-section.

2023 SB0376 Chaffee Written Testimony.pdf

Uploaded by: Jennifer Chaffee

Position: FAV

The Honorable Melony Griffith
Chair, Senate Finance Committee
Miller Senate Office Building, 3 West
11 Bladen Street
Annapolis, MD 21401

Dear Chair Griffith and Members of the Committee:

I am writing to ask you to support Senate Bill 376 which will allow increased birth options for Maryland Families.

SB376 allows women to access qualified birth providers of their choice, in their communities. Currently, the majority of counties in Maryland do not have hospitals where women can reliably access care for vaginal birth after cesarean section (VBAC). SB376 would allow Licensed Direct-Entry Midwives (LDEM) to provide that care to Maryland families just as they already do in more than 26 other states.

Maryland has a cesarean rate of over 30%, and closer to 40% for women of color. This means that more than a third of Maryland women are limited in their ability to choose a birth provider for subsequent pregnancies. The American College of Obstetricians and Gynecologists (ACOG) states that VBAC is a safe and responsible option for most women with a prior cesarean. SB376 is an important tool for increasing maternity care access and options for women across Maryland.

Please support Maryland families by voting 'Yes' on Senate Bill 376!

Sincerely,

Jennifer Chaffee
4122 Dee Jay Dr.
Ellicott City, MD 21042

SB376_OHora Testimony.pdf
Uploaded by: Kendra O'Hora
Position: FAV

WELLNESS & Co.

Monday, February 27th, 2023

The Honorable Melony Griffith
Chair, Senate Finance Committee
Miller State Office Building, 3 West
11 Bladen Street
Annapolis, MD 21401

Chair Melony Griffith and Members of the Committee,

"It feels so redemptive" - that's what I said after birthing my second son via VBAC in the comfort of my home this past New Years Eve.

In 2021, while pregnant with my first child, I was working with one of Maryland's Licensed Direct Entry midwives. In the last weeks of my pregnancy with my baby in the breech presentation, my midwife was forced to terminate my care under Maryland's regulations.

Unable to find another provider local to me, I was forced to travel to a neighboring state. After laboring 24 hours and a baby who wouldn't drop, the birth center and I chose to transfer to a hospital for more choices.

As a result, I had to have what was deemed as an "emergency c/s" (even though me and Baby were fine by all measures). At the hospital my written birth plan was not respected and my husband experienced extensive secondary birth trauma.

But I'm not just a mom who finally got her VBAC, I'm also Dr. Kendra O'Hora, a Licensed Clinical Marriage and Family Therapist and owner of a mental health practice in Harford County where I employee nine providers, two of which are perinatal mental health specialists working extensively with birth trauma.

Through my own two birth experiences in the last two years, through supervising my team, and through working clinically with women on their postpartum journey - I've seen firsthand the gaps in care in Maryland.

Senate Bill 376 is not just a lofty bill, it's necessary. I could go on and on about the statistics of the mental health prevention associated with women getting to choose their care team and birthing in the way that best suits them. And that data is important.

To me, more important is my personal testimony reminding you of the impact of a woman birthing vaginally after c-section: "*it feels so redemptive*."

I am here today - physically healthy, mentally well, and so strong because I got my VBAC.

It's time that my Licensed Direct Entry Midwife be able to deliver my *next* baby and that women all over Maryland be supported in their birth wishes of having a VBAC by these competent and professional care providers.

Thank you.

Sincerely,
Kendra A. O'Hora, PhD, Licensed Clinical Marriage and Family Therapist
Electronic Signature 2/27/2023 @ 12:03pm

2023 Kirra Brandon SB376 Written Testimony.pdf
Uploaded by: Kirra Brandon
Position: FAV

The Honorable Melody Griffith
Chair, Senate Finance Committee
Miller Senate Office Building, 3 West
11 Bladen Street
Annapolis, MD 21401

Re: Senate Bill 376

Dear Chair Griffith and Members of the Committee,

I am writing in support of SB 376. My name is Kirra Brandon. I am a practicing physician in Maryland and the mother of 5 daughters.

My personal motherhood journey began with the cesarean birth of my oldest daughter in 2007. She was born in Louisiana, a state with one of the highest cesarean rates in the nation. My medical opinion, as a physician, is that my cesarean birth was unnecessary. We know that many are. The world health organization advises that cesarean rates of 15% unnecessarily put women and babies at risk, and yet, the cesarean rate in the United States is 31.8% (2020 CDC Data).

I meticulously evaluated the risks and benefits of vaginal birth after cesarean (VBAC) at home with a Direct Entry Midwife with my husband (also a physician) and chose to have my second child at home. She was born in Texas, where Direct Entry Midwives have been licensed for decades. Direct Entry Midwives in Texas routinely attend VBAC births, and I was able to interview several different midwives and select the one that I wanted to attend my birth. My second daughter was born without incident at home.

In 2012, I moved home to Maryland (both my husband and I were born and raised in Maryland), where my 3rd, 4th and 5th daughters were born. It was difficult to find a direct entry midwife prior to their licensure in 2015, and even more so afterwards. Licensure of direct entry midwives made it easier for many women to get care with a direct entry midwife, but licensure made it nearly impossible for me (and any other woman seeking a VBAC with a direct entry midwife) to access the evidence-based care that I wanted.

SB 376 is incredibly important for women like me, women who have had a cesarean birth and do not want to unnecessarily accept the risks of another cesarean birth. Multiple cesareans are associated with significant risks to mothers and babies. Particularly for women who are planning large families, it is paramount that they have access to providers who are supportive of VBAC. Direct Entry Midwives are trained to attend VBAC clients and do so in the vast majority of states where they are licensed. They have an excellent record of safety and an impressive VBAC success rate. Upwards of 80-90% of women who attempt a VBAC with a Direct Entry Midwife succeed in delivering vaginally. This is a stark contrast to the hospital VBAC rates in Maryland which hover between 10 and 15%.

Women in Maryland should have the birthing options that women in so many other states have. They should not be forced to give birth in a location where they are less likely to actually achieve a VBAC. I urge you to support SB 376. It is a critical piece in increasing access to VBAC in Maryland, which will reduce the overall cesarean rates and eventually improve birthing outcomes.

Sincerely,
Dr. Kirra Brandon

2023 SB 376 MFSB Written Testimony.pdf
Uploaded by: Kirra Brandon
Position: FAV

The Honorable Melony Griffith
Chair, Senate Finance Committee
Miller Senate Office Building, 3 West
11 Bladen St.
Annapolis, MD 21401

Re: Senate Bill 376

Dear Chair Griffith and Members of the Committee:

Maryland Families for Safe Birth is submitting testimony in support of SB376. SB376 allows Direct Entry Midwives to care for clients with history of a prior cesarean birth. This will increase access to vaginal birth after cesarean (VBAC) for Maryland families.

Maryland Families for Safe Birth is a grassroots, consumer-driven organization, dedicated to improving access to evidence based, culturally sensitive maternity care for all Maryland families. We have an active membership of over 1700 Maryland families. Our organization frequently gets inquiries from women seeking a VBAC who are struggling to find a qualified, supportive provider.

In 2015, the Maryland Legislature passed a bill licensing Direct Entry Midwives. While this was a huge step forward, the restrictions on scope of practice in the bill that was passed, have made it MORE difficult for women with a prior cesarean birth to access care.

SB376 expands the scope of Direct-Entry Midwives to include caring for women with a prior cesarean birth. This is the standard of care in states where Direct Entry Midwives are licensed. Direct Entry Midwives are trained in their didactic and clinical training to attend Vaginal Birth After Cesarean (VBAC) births. The American College of Obstetricians and Gynecologists (ACOG) states that VBAC is a safe and reasonable option for most women with a prior cesarean. In spite of this, families in Maryland continue to have difficulty finding a VBAC supportive provider in many birth settings. Over 25% of Maryland counties do not have any hospitals willing to support a VBAC (see attached map).

Maryland's cesarean rate of 33.0% (2019 CDC Data) is the 14th highest in the country. This is well above the Healthy People 2020 goal of 23.9%. In addition, the cesarean rate among Black women in Maryland is significantly higher at 37.8% (Maryland Vital Statistics 2019 Report). The scope restriction on VBAC for Direct Entry Midwives disproportionately affects families of color and further limits their care options in the setting of a maternity care system that delivers worse outcomes for Black families at baseline.

Maryland's VBAC rate is 16.5% (2018 CDC data). In contrast, Direct Entry Midwives routinely have VBAC success rates upwards of 85% with excellent outcomes for both moms and babies.

Direct Entry Midwives in Maryland report a substantial increased interest in out-of-hospital birth during the COVID pandemic. If anything, COVID has taught us that the risk/benefit ratios for where we choose to give birth are not static. Yet, nearly 1/3 of women in Maryland are not afforded the option to weigh their own individual situation when choosing a care provider or birth location.

We urge you to support this bill. Let's increase access to maternity care options for Maryland families, not unnecessarily limit them.

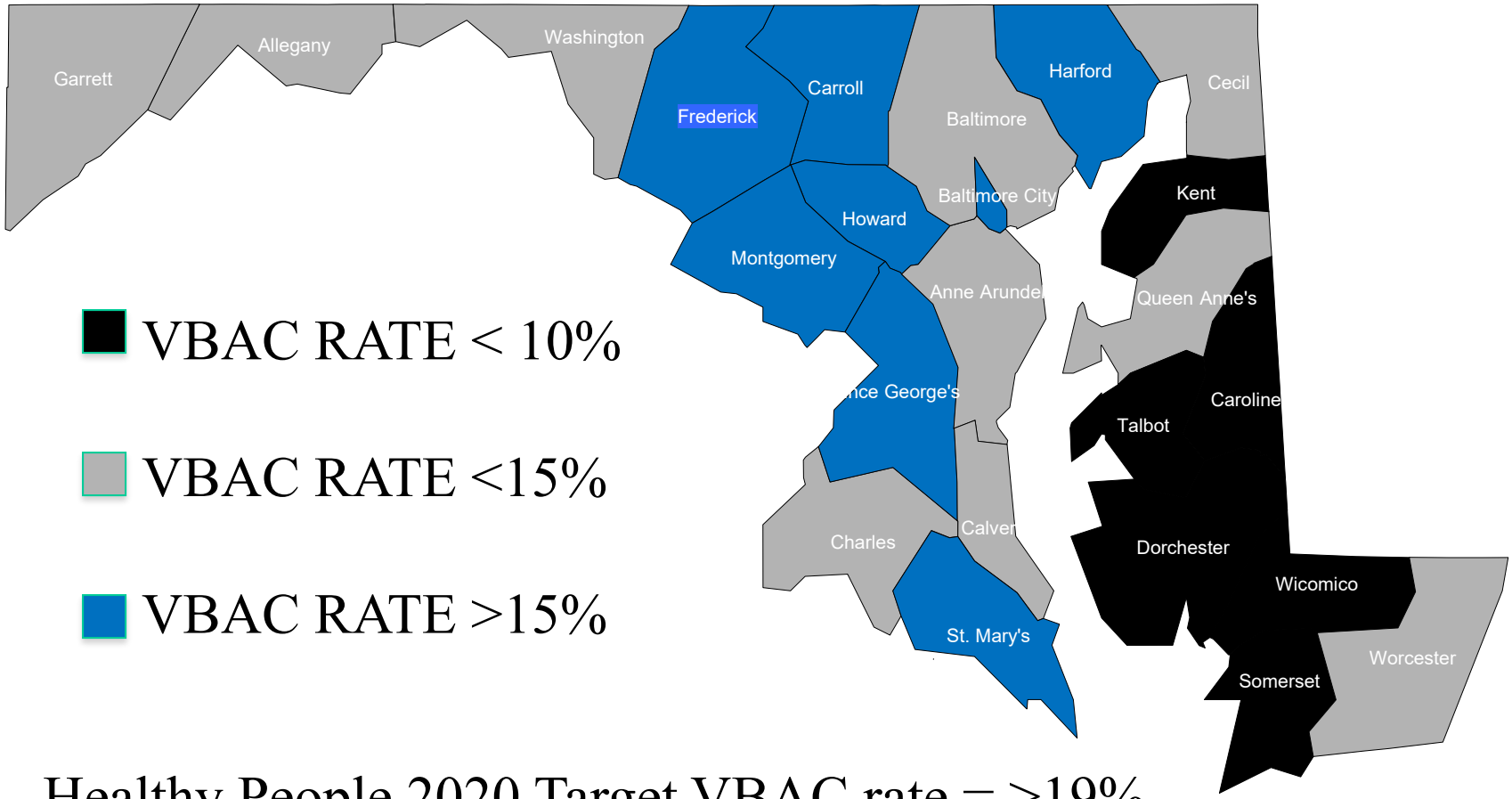
Sincerely,

Maryland Families for Safe Birth

Kirra Brandon MD
Evie Fielding
Jennifer Chaffee

Maryland VBAC Rate Map 2015-2018.pdf
Uploaded by: Kirra Brandon
Position: FAV

2015-2018 VBAC RATES IN MARYLAND



Healthy People 2020 Target VBAC rate = >19%

*data from March of Dimes Peristats

Submitted by Maryland Families for Safe Birth

SB0376 Support Nikki Williams.pdf
Uploaded by: Nikki Williams
Position: FAV

NIKKI WILLIAMS
LDEM, LM, CPM, CLC
Certified Professional Midwife

The Honorable Melony Griffith
Chair, Senate Finance Committee
Miller Senate Office Building, 3 West
11 Bladen Street
Annapolis, MD 21401

26 FEB 2023

Dear Chair Griffith and Members of the Committee:

I am a Maryland LDEM and Virginia LM, and I have been regularly attending home VBAC my entire birthwork career. My first birth as a doula 13 years ago was a home VBAC (HBAC).
I then regularly attended HBACs in my own midwifery training in Germany, England, and in Virginia at a birth center. What is different there is that they put human rights and parental choice above the potential discomfort of a care provider.
I am currently working with a joint CNM/LDEM practice with stellar statistics spanning 12 years that include:

- 623 total home births
- 5.8% cesarean rate
- 64 VBACs completed at home (88% success)
- 6 transferred for safe appropriate repeat cesarean, thanks in part to the collaboration relationship we have personally fostered with our two most local hospitals.

Because I have always been attending VBACs at home in some primary care or support capacity, I already have a robust informed choice document that helps clients make the choice that is right for them. It is four pages long. Sometimes, the right choice is actually a planned repeat cesarean. But we need to be clear that pregnancy after cesarean also has its own risks. A planned cesarean has its own risks. An emergency cesarean has its own risks. A very first pregnancy has its own risks. Midwives excel at and take pride in helping clients understand their individual risk within their individual situation, via the one-on-one care that we have the luxury of providing. This is what keeps homebirth safe.
I also regret to announce that we have recently lost two beloved safe VBAC-attending homebirth CNMs in Maryland to retirement. The area I practice in is now relying on one single CNM to serve the HBAC desires of dozens of people. Yes, we can continue to have people moving into trailers just across the state line to West Virginia or Pennsylvania to give birth with LDEMs or unregulated midwives, but how is this protecting anyone's safety?

I urge your support for Senate Bill 376 on behalf of the hundreds of families who want a better chance at protecting their reproductive future.

Thank you,
Nikki Williams

nikki@bedheadbirth.com • www.bedheadbirth.com
Mobile: 443-857-2412 Fax: 833-356-2456
13922 Penn Shop Road, Mt. Airy, MD 21771

2023 ACNM SB 376 Senate Side FAV.pdf
Uploaded by: Robyn Elliott
Position: FAV

AFFILIATE OF
AMERICAN COLLEGE of NURSE-MIDWIVES
With women, for a lifetime®

Committee:	**Senate Finance Committee**
Bill:	**Senate Bill 376 - Health Occupations – Licensed Direct-Entry Midwives – Previous Cesarean Sections**
Hearing Date:	**February 28, 2023**
Position:	**Support**

The Maryland Affiliate of the American College of Nurse-Midwives (ACNM) supports *Senate Bill 376 – Health Occupations – Licensed Direct-Entry Midwives- Previous Cesarean Sections.* ACNM recognizes that the licensed direct-entry midwife (LDEM) community is educated and certified in a different pathway from the one we represent. Our review indicates that provision of vaginal birth after Cesarean (VBAC) is part of their educational program.[i] Families who are making an informed choice about place of birth and qualified health care providers deserve support for that choice. When counseling and documentation of specific consent to attempt VBAC are provided, families are able to make an informed choice regarding place of birth, and we believe that this choice should be supported. If we can provide any further information, please contact Robyn Elliott at relliott@policypartners.net or (443) 926-3443.

[i]Citation: Midwifery Education Accreditation Council. 2014. Curriculum Checklist of Essential Competencies. https://www.meacschools.org/wp-content/uploads/2021/02/Curriculum-Checklist-of-Essential-Competencies-rev-2014.pdf

SB376 - Support - Katie Dongarra.pdf
Uploaded by: Valerie Skvirsky
Position: FAV

The Honorable Melony Griffith
Chair, Senate Finance Committee
Miller Senate Office Building, 3 East
11 Bladen Street
Annapolis. MD 21401

Chair Griffith and Members of the Committee,

I'm writing to you today in favor of SB376. As a mother of two who has given birth twice I strongly believe in a woman's right to choose the care provider she feels most comfortable with at her birth.

My first birth was in the state of GA in 2010. Like MD at the time, CPMs we're not quite legal. However I've known pretty much since I was a kid that if I ever gave birth I'd use a home birth midwife. So I hired one while also paying for and attending concurrent care at a hospital practice. This gave me peace of mind that if I ever had to transfer it wouldn't be into a hostile and unknown territory with providers I'd never met. Though, only one provider in that practice knew my actual plan to attempt a home birth first. That always felt dishonest and uneasy for me, but I believed very strongly in the care providers I had hired and knew they are who I would feel most comfortable with during one of the most transformative moments of my life. I did have a non-emergent transfer for that baby and my back up plan went well.

Years later, back in MD, I was planning for my second home birth. Again, the state I lived in hadn't yet legalized CPMs, or direct entry midwives. Regardless I knew I felt most comfortable being cared for by a CPM. I had interviewed a few and knew without a doubt who I wanted to care for and guide me during my pregnancy and to attend my birth. But once again I incurred double expenses and sacrificed additional time during my pregnancy attending redundant appointments by hiring backup care with a hospital provider in case I had to transfer. Should that need arise I wanted it to be a smooth transition. Fortunately, this time I gave birth successfully at home.

All in all I feel fortunate for my pregnancies and birth experiences. While I wish I hadn't needed to transfer the first time I was fortunate to have received care from two different systems to ensure that my experience, physically, emotionally and mentally was one that I wasn't traumatized by.

During my pregnancies and years of small babies I met up with many other mothers through a birth group to discuss birth and early childhood. Without a doubt birth is one of the most, if not THE most, transformative moment in a woman's life. I've heard numerous stories from many mothers who weren't as fortunate as I and didn't feel they were given choices during their birth and the

subsequent impact that had on them, their babies and their families. I've also talked with moms who knew they didn't have a choice of the provider they hoped for so made the decision to birth unassisted anyway, because while that was a risky choice it was less scary/risky to them as choosing the provider they didn't want and risking more trauma from care they didn't consent to.

Direct entry midwives are highly capable and trained in birth. In my experience with concurrent care during two pregnancies they spent nearly 4x the amount of time with me and cared for me much more holistically than my backup providers. I was able to discuss any and all fears prior to birth and they would share the ways in which they're trained to notice anything that is not a normal or safe birth prior to an emergency arising. Direct entry midwives play a crucial role in caring for mothers and families in Maryland and as such are much needed for VBACs. The World Health Organization tells us that a 15% cesarean section rate is healthy. Maryland's rate is more than double that and one of the highest in the country. C-sections are not without risk and oftentimes leave women with severe trauma and physical ailments. Some of our counties have ZERO VBAC providers. Maryland should be leading the way as an example of a state that believes in a woman's right to choose who her care providers are, not leading the way in atrocious stats of unnecessary surgical births. The time is now to pass this bill, the health of our families depends on it!

Thank you for taking the time to read my testimony. Please join me in supporting this bill and informed choice in Maryland.

Respectfully,

Katie Dongarra

Katie Dongarra
1333 Heather Hill Rd
Baltimore MD 21239
(410) 490-4978

SB376 - SUPPORT - Meg Ruzicka_.pdf
Uploaded by: Valerie Skvirsky
Position: FAV

February 28, 2023

The Honorable Melony Griffith
Chair, Senate Finance Committee
Miller Senate Office Building, 3 East
11 Bladen Street
Annapolis, MD 21401

Re: SB376 – Health Occupations – Licensed Direct-Entry Midwives – Previous Cesarean-Section

Chair Griffith and Members of the Committee,

My name is Meg Ruzicka. I am a mama and a birth and postpartum doula here Maryland. Above all else, I am a person. I like having choices and making them myself. I like feeling empowered by these choices because I am informed on the benefits and risks of them. And that's exactly what I felt during my second labor.

As a double cesarean mama, I went for the Home Birth After A Cesarean (HBAC). I was surrounded by people who believed in me. People who helped me feel heard and seen and loved, no matter what choices I made. My first birth was full of trauma and one that I look back on a lot, I didn't feel empowered or like I had many choices.

I really think that's all women want.. the choice. The choice to be strong, to be seen for the trials they are going through. The choice to feel like what they are doing is okay. To choose a provider who helps them feel safe and advocated for. And that, to me, meant a home birth midwife for my labor. I had a CNM attend my second labor in my home and, again, it was the love and support that helped me feel stable.

As a doula, I witness so much mental instability surrounding the birth and postpartum experience. I really think it needs to change— the system, and the ability to just simply labor with someone who makes you feel safe.

I'm grateful for western medicine and how cesareans do save lives. I understand the risks. I am also so grateful for our home birth midwives, who are trained medical professionals and the connection they provide their clients. I believe that women are safe in the hands of our midwives, who are passionate about what they do. I believe that women should get the power to decide who they want attending their births, and where they birth their babies.

Thank you.

Megan Ruzicka
2132 Phillips Mill Rd
Forest Hill, MD 21050

SB376 - Support - Pamela Terranova.pdf
Uploaded by: Valerie Skvirsky
Position: FAV

The Honorable Melony Griffith
Chair, Senate Finance Committee
Miller Senate Office Building, 3 East
11 Bladen Street
Annapolis, MD 21401

Re: Personal Testimony in Support of Senate Bill 376 – Health Occupations – Licensed Direct-Entry Midwives -Previous Cesarean Section

Dear Chair Griffith and Members of the Committee:

My name is Pamela Terranova, and I am a resident of District 41. I am writing today to encourage you to vote in favor of SB 376, expanding a woman's right to choose Vaginal Birth After Caesarean (VBAC) support that includes certified professional midwives (CPMs). Aside from being qualified in their didactic learning to attend VBACs, CPMs stand poised to play a critical role in healthcare today. At a time when hospital staffs and resources are stretched thin, an option to keep otherwise healthy births to willing parents at home when risks of adverse effects are low is both logical and prudent. But you will hear all about the logic and statistics from others much more qualified than I am. What I can contribute is a first-hand account of who a bill like this would serve.

I had known for years that my first birth would be a homebirth. I'm a chiropractor by trade, and my specialty is in prenatal care. I have spent the last nine years serving Maryland parents to prepare them for birth. I have seen what a birthing body is capable of without interference. So when I was expecting a child of my own in 2019, I was thrilled to allow my body to do what it was designed to do. I chose a homebirth because I knew that I would just need guidance and support – reminders that what I was experiencing was normal and natural. I didn't want to be distracted from the physiological progression of my pregnancy and birth. I trusted myself, and I trusted my midwife to fill in the blanks that I couldn't. As it turns out, my son had other plans. I like to think he was preparing me to serve a broader spectrum of patients in practice. He was also testing the skills of my birth team – and they rose to every challenge.

I had a long pregnancy – I didn't go into labor until 41 weeks and 6 days, which already would have led most hospitals to be pushing me to an induction. This is despite the fact that a baby is not technically 'past-due' until 42 weeks. My baby was just comfortable in utero – my CPM sent me for an ultrasound earlier that day to confirm as much. When my labor came on stronger, my team assembled. Things were progressing well…until they weren't. My son was just fine, but he had rotated and gotten quite cozy. So my labor stalled. And stayed stalled for two days. You read that right – I was in active labor, unmedicated, at home, for two whole days. And I would do again in a heartbeat.

My midwife and her assistants watched and waited. They conferred and discussed options with my husband and me. They included me in their decision making. And they did not rush me to any decisions. Because even when my body was struggling to birth my baby on its own, my person was still something to be consulted and heard. They knew that the adage, 'healthy baby, healthy mom' is not enough and diminishes the extraordinary experience of becoming a parent. So they gave me time – something our medical system is not always equipped to do. Knowing my baby was healthy, but that my body was fatigued, they guided me to the responsible decision of a transfer.

There is nothing quite like being a homebirth-transfer to a hospital. It was like the worst walk-of-shame you can imagine. The providers there had been forewarned by my midwife that we were coming in, records transferred, and the stage set to take on the person who didn't want to be there in the first place. Everyone has their biases, and it's hard to mask them when we are fatigued – which is how I explain the fact that the OB at the end of her shift when I presented to the hospital hadn't even allowed me to get my epidural in place before she was recommending a Caesarean. Mind you, my whole birth plan – years in the making – had just crashed down around me. I had agreed to a transfer to get some rest with pain relief and fluids since my son was doing fine, comfortable as ever. So there was, again, no need to rush. But she pressured and shamed me for asking questions and making an informed and educated decision to see if I could still deliver on my own. Was I not as confident in my knowledge and preparation for birth, and not surrounded by my support system (something that would not be possible with today's remaining COVID protocols in a hospital setting), I'm sure I would have wavered and been rushed into a surgical birth, entirely unprepared mentally and left to question (even more than I still do) had I really done everything possible to try and avoid a C-section. It can not be understated the effect this can have on the newly-postpartum family. From a delayed onset of lactation, interrupted bonding – the decision to have a Caesarean should not be made lightly. And it was with a very heavy heart that we eventually made that decision for my family.

But unlike most new families, I was acutely aware of what implications this birth had not just for my newborn, but for every subsequent birth I might be honored to have. There are only three CNMs that serve homebirth clients in Baltimore. They are typically booked up months in advance, meaning if they aren't your first call after you see those two lines on a pregnancy test, you may be entirely out of luck. This makes it more likely that, even though a VBAC is a safe and recommended option for most parents, anyone due this year would be in a hospital system that discourages even trying to labor. It is exhausting having to advocate for your wishes with a provider with whom you are not on the same page – especially when you are gearing up to do something as labor-intensive as give birth. It takes a certain amount of bravery to attempt something that you have already been unsuccessful in doing when you know the many benefits of doing it must outweigh the fear of failure. You will waiver, and in those moments, you need the support of a provider who truly believes in your abilities as a birthing person. Midwives are uniquely positioned to be these caregivers – but we need more of them as demand rises in a state where the first time Caesarean rate is far above the WHO-recommended standard (34% compared to the goal of 10-15%). There is no clear reason as far as I can see to prevent this bill from passing – midwives have the heads, hands, and hearts to change the trajectory of so many lives. As my husband and I prepare to expand our family in the near future, I await your responses eagerly.

Thank you for your time,

Pamela Woodward Terranova, DC
Baltimore, MD 21210

SB376 - SUPPORT - Roxann Gordon.pdf
Uploaded by: Valerie Skvirsky
Position: FAV

02/26/2023

To: The Honorable Melony Griffith Chair Senate Finance Committee
Miller Senate Office Building 3 West
11 Bladen Street
Annapolis, MD 21401

Dear Chair Griffith and Members of the Committee

Testimony in Support of SB 376 Expansion of LDEM/CPM scope of practice to include Clients seeking TOLAC/VBAC providers who meet established criteria set forth in the bill

My name is Roxann Gordon I have been a R.N. for 22 years and a C.N.M. for 17 years and am currently Chairperson of the LDEM Advisory Committee of the Maryland Board of Nursing.

I am here today to support this bill based on my years of experience attending births in birth centers, hospitals and at home. I am one of the few CNMs- Certified Nurse Midwives in Maryland offering out of hospital Midwifery services and I am faced on a weekly basis with turning away women and families who are seeking a health care provider for TOLAC/VBAC.

Testimony and statistics compiled and presented to the committee show that for low risk clients who meet guidelines of only 1 C/Section/surgical birth- documented LTSC incision with an 18 month interval between last birth and due date of current pregnancy are acceptable candidates for out of hospital birth TOLAC/VBAC with Midwifery Care.

Due to the testimony given here today, the issues related to Autonomy, Access and Acceptable risk its evident that we need more providers in the community to meet the demand of women and families seeking birth options, and access to safe qualified, trained Midwives of all educational pathways. This need is not being met by area hospital institutions whose VBAC success rates average 7-15 % versus 70-85 % success rates for Homebirth Midwives in Maryland.

Many hospital guidelines/protocols in Maryland do not support VBAC. Individual physicians can be anti-VBAC due to their beliefs and liability concerns. Increased healthcare costs for surgical birth are well known. As Women continue to fight for choice, for birth options and reproductive rights across the country I ask our Maryland Senate and the committee members to follow the lead of our new Governor Wes Moore in protecting the rights of women to choose how, where and with whom families choose for their healthcare provider and to increase access to these much needed services that can be safely provided by CPM/LDEM Midwives.

Respectfully submitted,

Roxann Gordon

Roxann Gordon RN, BSN, MS, CNM
Birthing Babies Midwifery Care
13615 Voland Ct. Dayton, MD 21036
Birthrox@comcast.net

SB376 - SUPPORT - Sharon Dongarra.pdf
Uploaded by: Valerie Skvirsky
Position: FAV

The Honorable Melony Griffith
Chair, Senate Finance Committee
Miller Senate Office Building, 3 East
6 Bladen Street
Annapolis. MD 21401

Chair Griffith and Members of the Committee.

I am writing in favor if SB376.

My name is Sharon Dongarra. I'm a wife, a mother, a homebirth advocate and a chiropractor who has had the honor and privilege of caring for pregnant people in and around Baltimore for the last decade.

In my experience, when the topic of healthcare comes up legislatively the conversation tends to center around cost and access. Today, we have the opportunity to discuss a different, yet equally important, aspect of healthcare and that is consent to care.

When my wife became pregnant with our daughter we knew right away that we wanted to have a homebirth. It was never a question for my wife that she valued the experience of a completely natural labor if at all possible. We lived in Georgia at the time and homebirth there was legal but it was not regulated by licensure as it is here in Maryland. We carefully chose a very competent and experienced midwifery team. We also decided to pursue concurrent care with a hospital based midwife. Being gay in the Deep South we felt that should the need to transfer care arise it would be prudent to have an existing relationship with a provider.

I've often shared that for nine months we attended prenatal visits where we would spend ten minutes waiting for an hour long visit with the homebirth midwife. Then we would wait an hour to spend ten minutes with the hospital based one. They were both caring and educated providers. They were both focused on the health of my wife and unborn baby. But without the constraints of a high volume practice the homebirth midwives were in a much better position to care for not just the medical needs that pregnancy requires but the emotional, psychosocial and educational aspects as well. We spent a lot of time getting to know all of our choices and options.

My wife started showing very early signs of labor on a Thursday morning. She labored at home safely but sporadically until eventually, although my wife and baby were safe and strong, it became clear that she needed some help to get her contractions more consistent for birth. The homebirth midwife determined it was time to transfer to our hospital team.

We arrived at the hospital and they gave her an epidural which allowed her to nap, they hydrated her and they started her on pitocin to enhance her contractions. Eventually it was time to push and she did so like a champ. I'll never forget the moment my daughter was born. Our homebirth midwife, now functioning as her doula, leaned over and whispered in her ear, "The next one will be a piece of cake." Although her birth didn't go as planned it was a beautiful, solid

plan B thanks to the care and cooperation of those providers. And she held those words close to her heart for a long time.

Maryland has already determined that homebirth has a place in healthcare. And during the pandemic more families than ever chose this method of care to grow their families.

Today, I'm writing to you with the people on my heart who I've met and talked to who weren't as fortunate as my wife. Maybe they didn't have as many choices laid out for them or as much support available to them or maybe a c-section became the only viable option for a safe birth. People who still want a vaginal delivery or even a delivery at home. I'm particularly concerned for those who have shared that they feel trauma about how their birth transpired and how vulnerable they feel going to the hospital again. That having a major abdominal surgery and then recovering from it with an infant was incredibly hard and they can't imagine doing it with a toddler too. People who want VBACs and can't find providers willing to support them.

Maryland CPMs are highly educated, and extremely competent professionals. This is already established. They acknowledge that a cesarean after a cesarean is not without its own risks. And they acknowledge that not everyone would be a candidate for a homebirth VBAC. They also acknowledge that according to their expertise many are. And where a person decides to have their baby when they are properly informed of the risks and benefits associated should be left up to the consumers and the providers tasked to care for them.

Consent to care is not a partisan issue. We all agree that access to medical care is an essential human right. We believe that people should be able to determine what healthcare choices are right for them. Our individual values may differ but the idea that our bodies are sovereign is universal.

Four years after my daughter was born, my wife attempted another homebirth. This time, it was (mostly) a piece of cake. My son entered this world in the same room that my mother passed from this earthly plane just a year before. And it occurred to me in those days that some things are sacred. We are all born and we will all eventually pass. Where that happens should be determined not by laws or restrictions made for the masses or for the ease of institutions but by the choices of informed consumers and educated providers.

Please, join me in supporting the people this bill aims to protect. Support informed choice. Support SB376.

Respectfully,

Sharon Dongarra, DC
1333 Heather Hill Road
Baltimore, MD 21239
(410) 490-4976

SB376 - Support - Tova Brody Birth.pdf
Uploaded by: Valerie Skvirsky
Position: FAV

Tova Brody Birth LLC

3417 Old Court Road, Pikesville, MD 21208 ♦ TovaBrodyBirth@gmail.com ♦ Phone 410.504.7798 ♦ Fax 435.579.4320

February 28, 2023

Chair Griffith and Members of the Finance Committee:

My name is Tova Brody and I am a Licensed Direct Entry Midwife/Certified Professional Midwife (CPM) that serves clients in and around the Baltimore area. I am writing this letter to ask for your support for SB376, which would expand the scope of practice for CPMs to attend clients planning a VBAC (vaginal birth after cesarean).

The scope expansion is extremely straightforward - it merely moves VBAC from the 'prohibited' list in the regulations to the 'requires consultation with another medical provider' section. A simple cut and paste switch that would change the births and lives of so many who seek this service.

There are over 30 states that license CPMs, and the vast majority of those allow this within scope of practice. The requirements included in this particular bill, that a client would need to meet to be a candidate for a TOLAC (trial of labor after cesarean) in the out of hospital setting, are extremely thorough and more restrictive than many other states that allow LDEMs to attend VBACs.

We, as providers, are educated, trained, and completely competent. We always provide our clients with up to date, evidence-based information when it comes to making decisions for their births, and use that same research to stay current with our own practice.

These clients are low risk. And we, as midwives, are always continually screening them to ensure they retain that status. Should they risk out for any reason, we have systems in place to transfer them to the hospital setting.

These clients are not few. There are many. The state of Maryland has a 34% cesarean rate, with some individual hospital rates being as high as 49%. That's anywhere from 1 in 2 to 1 in 3 mothers who may need this service. Over half of the counties in Maryland do not have access to OBs or hospitals that allow VBACs. LDEMs are turning away these prospective clients all of the time. There are not enough out of hospital CNMs to meet the need.

These clients are educated and well-informed. They are specifically seeking out of hospital care, often because the doctors they used previously either do not offer this service, or do not have adequate success rates.

As of 2018, the overall rate of VBACs in Maryland was 16.5%. Out of hospital VBAC success rates, based on local CNM practices, range from 80-90%.

On a personal note, I primarily serve the Orthodox Jewish community in Pikesville. It is the norm for families to have many children. Having limited to no access to VBAC care creates tremendous risk for clients who wish to have many children and also puts a cap on their family size. There are only so many surgeries a uterus can tolerate. More unnecessary cesareans are not only dangerous for the mother, they also negatively impact neonatal morbidity rates. I

receive multiple calls every month from VBAC hopeful clients who wish to access CPM care and are so frustrated that they cannot.

We ask for your support on this extremely straightforward matter. It will make a tremendous difference for Maryland families by increasing safe, autonomous birthing options. And it will allow midwives to do what they are trained and capable of.

Thank you for your time and consideration,

Tova Brody, CPM, LDEM

SB376 - SUPPORT - WomanWise.pdf
Uploaded by: Valerie Skvirsky
Position: FAV

homebirth & women's health

WomanWise

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2/28/2023

Chair Griffith:

My name is Karen Webster. I'm a licensed Direct Entry Midwife (LDEM) in both Maryland & Delaware. I have been attending home births since 1979 and have been in practice since 1985. I have been both a clinical and faculty preceptor for 3 accredited midwifery colleges for over 25 years. *I turn prospective clients away weekly because I'm not allowed by our regulations to attend their VBAC births.*

Direct Entry Midwives are trained in their didactic and clinical education to attend VBAC and this is the standard of care in most of the 37 states where Direct Entry Midwives are licensed.

Since Maryland passed it's Direct Entry license statute in 2015, only CNMs (Certified Nurse Midwives) have been allowed to attend home VBACs (vaginal birth after cesarean). I live in Cecil county and practice in Cecil, Harford and several Eastern Shore counties, where there are no CNMs practicing in the home birth setting, either in the past 38 years or currently. That leaves a vast number of Maryland women who desire a home VBAC unserved and with very few options for a vaginal birth in a Maryland hospital where VBAC success rates are very low (10-15%) as compared to success rates with a homebirth LDEM. (85%)

I have kept my own practice statistics in NARM's National Data Base and my VBAC success rate over the past 30+ years has been around 83%.

I urge you to listen to the women and families of Maryland and please vote in support of this Bill to increase our scope of practice so we can meet our goals to:

- Lower Maryland's high cesarean section rate – 33.7%
- Increase access to Vaginal Birth After Cesarean (VBAC) in all birth settings

Many thanks for your service,

Karen S Webster

Karen S Webster, CPM, LM (DE & MD)

SB376- Support - Deanna Kopf_.pdf
Uploaded by: Valerie Skvirsky
Position: FAV

The Honorable Melony Griffith
Chair, Senate Finance Committee
Miller Senate Office Building, 3 East
11 Bladen Street
Annapolis, MD 21401

RE: SUPPORT FOR: Senate Bill 376-Health Occupations
Licensed Direct Entry Midwives, Previous Cesarean Section

February 28, 2023

Dear Chair Griffith and Members of the Committee,

As a Licensed Direct Entry Midwife in Maryland, I wholly support SB376. The options for birthing people who've had a previous c-section and are seeking a vaginal birth in Maryland are sorely lacking. Many hospitals don't allow VBAC, and some counties don't have any hospital options at all. The only option for those people is more c-sections if they plan to have more children. The risk of multiple surgical births is higher compared to a VBAC after one or 2 c-sections. MD needs more options for VBAC! This is where CPM's can make a great impact for these birthing people.

Maryland has a primary c-section rate of about 34%. Most hospitals have a c-section rate of on average around 30%, whereas homebirth midwives have a c-section rate of about 5-10%. On the other hand, MD's VBAC rate is 16.3% (the national rate is 13%). Studies show that out of hospital midwives have high VBAC rates (as high as 95%!). Studies also show that the rate of uterine rupture after a cesarean is extremely low. CPM's provide safe, evidence-based care. We spend a lot of time during the prenatal care educating clients and preparing them for their birth, as well as making sure they stay low risk and are a good candidate for out of hospital birth. We provide careful monitoring during labor to ensure the birthing person and their baby are safe, and we have protocols in place for transfer to the hospital should complications arise.

As a student midwife, I attended many successful VBAC's at home with my preceptor, a CNM. I was very disheartened when I became a licensed midwife and was not able to attend clients who had a previous cesarean. Since I've been licensed, I've turned away more clients than I can count, who were seeking a vaginal birth after a previous cesarean. These people desperately wanted a care provider who believed in them and their body's ability to birth their baby, something they didn't feel they would get with a hospital provider. Many of these birthing people had suffered a traumatic birth in the hospital and did not want to return to the same system they felt betrayed by. Additionally, although the c-section rate for people in my care is low (about 3-10%), people who needed a c-section while in my care may want to return to me for future pregnancies and that isn't possible unless we pass this bill. Some people who've had a previous cesarean may also choose unassisted birth if they feel they don't have safe options for a provider who will attend them at home. It is in their best interest, and the best interest of their babies, to have safe, legal options for out of hospital providers who can attend them.

I ask that you please consider the many consumers who are affected by cesarean births, and support SB376 for Direct Entry Midwives to provide more safe birthing options for Maryland Families.

Sincerely,
Deanna Kopf, CPM, LDEM
Owner, Birthwise Midwifery LLC
birthwisemidwives@gmail.com

SB376-SUPPORT- Paige Barroca.pdf
Uploaded by: Valerie Skvirsky
Position: FAV

MOONSTONE MIDWIFERY
Paige Barocca, LDEM, CPM
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Paige@moonstone-midwifery.com

The Honorable Melony Griffith
Chair, Senate Finance Committee
Miller Senate Office Building, 3 West
11 Bladen Street
Annapolis. MD 21401

Re: Senate Bill 376 - Finance - Licensed Direct-Entry Midwives - Previous Cesarean Section

Dear Chair Griffith and Members of the Committee:

I am writing today in support of SB376, a bill that will increase access to safe vaginal birth after previous cesarean (VBAC) by broadening the scope of Licensed Direct Entry Midwives (LDEMs).

Before becoming a Licensed Direct Entry Midwife, I worked as a registered nurse for 8 years on a unit that served psychiatric patients. Initially, when I entered the world of nursing, I thought I would be a labor and delivery nurse. In the short time that I spent in my clinical training on an L&D floor, I knew that wouldn't be the path for me. It was clear that nurses on the maternity ward functioned similarly as those on a medical/surgical unit, very task oriented and too bogged down to provide that one-on-one care needed during such an intimate time for their patients. I ultimately chose to work as a psychiatric nurse in an effort to preserve the personalized side of nursing, the reason why I became a care provider in the first place.

Fast forward a few years, I've met my husband, who is also a psychiatric nurse and born at home in the 1980's, a match made in heaven. It was obvious to the both of us that we would pick our home for the planned birth place of our first child. I fell in love with the intimate, hour-long prenatals that I had. When, after careful monitoring and diligent midwifery support, we had to move our birth place to the hospital for a postdates induction, I felt ill prepared for the amount of scrutiny I would face, along with the autonomy I would lose during my own birth process. I was left with what I now see so often after a hospital delivery, birth trauma. Although I was able to preserve my vaginal birth in the hospital, it seems only by the skin of my teeth, and quite literally under threat of the knife in the final hour. I have since had two safe, beautiful, and healing home births. I can't say that my story would be the same or what my journey would look like if I had a cesarean section.

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Prior to becoming a midwife, I worked as doula, providing emotional and physical support for many planned hospital births. I saw time and time again that people on a Labor and Delivery unit simply weren't given the autonomy that my patients on the Psych unit had. While I had patients refusing medications without recourse, my doula clients were often coerced into abandoning their own birth plans based on policies and procedures in hospitals that are not evidence-based (such as continuous fetal monitoring, lack of nourishment in longer labors, bedrest after their waters rupture, cesareans without the option for ECV- safe manual turning of the baby in a breech presentation, and restricted opportunity for TOLAC or VBAC). I once witnessed a provider walk in and say to a client in labor, "I can tell just by looking at you that you won't birth vaginally." Guess what, she did! This same client hired me for her second baby, along with a more supportive hospital. She had a successful ECV for her surprise breech baby at 42 weeks, which she then birthed vaginally at over 11lbs! Without complications, by the way.

These are the stories you need to hear. People having beautiful births in circumstances that are otherwise deemed "dangerous" or even "impossible" under the wrong light. Yes, these supportive hospital births do exist, but they are few and far between. Way more common are the hospitals that say that a VBAC is possible, then at last minute schedule a cesarean. Or, worse, they don't allow VBACs at all. The medical mindset around birth has completely tainted our world's view when it comes to welcoming our future generations.\ I became a midwife to empower parents. I strongly believe that empowered, resilient parents will raise empowered, resilient children. Our society can only benefit from this model of care.

I eventually left nursing and doula work all together. I pursued an apprenticeship with a home birth midwife, rather than going to school for certified nurse midwifery (CNM), so that I could focus on the midwifery model of care. After my initial hospital transfer, I was inspired more than ever to provide the kind of care that my home birth midwife team provided. Validating, holistic, competent, and attentive care that every pregnant person should have the privilege to experience. Unfortunately, here in Maryland, when cesarean rates are twice the recommended rate, and many hospitals have policies that restrict access to VBAC, there is a very large population of people who don't have access to the type of birth they not only desire, but deserve.

Please vote in support of SB376. If not for me, for our Maryland families.
Respectfully,
Paige Barocca, CPM, LDEM

SB376-SUPPORT-Nikki Williams.pdf
Uploaded by: Valerie Skvirsky
Position: FAV

NIKKI WILLIAMS
LDEM, LM, CPM, CLC
Certified Professional Midwife

February 28, 2023
The Honorable Melony Griffith and Members of the Committee
Senate Finance Committee
Miller Senate Office Building, 3 East
Annapolis, MD 21401
Re: Senate Bill 376 - Health Occupations - Licensed Direct-Entry Midwives - Previous Cesarean Section

Position: Support

Dear Chair Griffith,
I am writing to you to urge your support of SB 376.
I am a Certified Professional Midwife, licensed since 2020 in both Maryland and Virginia. I have experience supporting VBAC (Vaginal Birth After Cesarean) in the out-of-hospital setting since 2010, in the United States (Maryland, Virginia, and West Virginia), and in Germany and England.

As a licensed out-of-hospital birth provider in Virginia who can legally provide VBAC, my current VBAC success rate, albeit with a small sample size, is 100% with 0% maternal or infant morbidity and mortality in both the home and birth center settings. Incredibly, as an example of another targeted regulation used to restrict midwifery access, Virginia does not allow CPMs to carry lifesaving medications of any kind, to include Pitocin or IV fluids, yet gives consumers the choice to weigh their personal risks and benefits of pursuing any type of out-of-hospital birth with a CPM, to include VBAC.

Last year, I attended a client who moved from her home in Pennsylvania to her parents' home in West Virginia in order to receive care to prepare her for a home birth after Cesarean (HBAC), because of the "VBAC Ban" (refusal to provide Trial of Labor After Cesarean (TOLAC) in her local hospital. This is a relatively common scenario and one that does not improve safety.

If people want a VBAC, they will move mountains to have a VBAC, which implies the role of financial and social privilege in their ability to achieve one. This then creates further health disparities in Maryland where disadvantaged people will have no choice but to subject themselves to a repeat cesarean with its myriad health risks, to include hemorrhage, infection, hysterectomy and placenta previa. Many women with a cesarean scar in Maryland who want a chance at a vaginal birth, with an 99.5% chance of an intact uterus, now feel forced to attempt to give birth alone, or with an untrained attendant, or with a trained attendant who has to travel from long distances out of Maryland to an unfamiliar hotel or AirBnB to attend them. This does not improve safety, especially in the context of ACOG's (American College of Obstetrics and Gynecology) statement that VBAC "*be*

performed in a facility with the ability to begin emergency cesarean delivery within a time interval that best considers maternal and fetal risks and benefits with the provision of emergency care." This encompasses every single person who is in labor, not just people attempting a VBAC. If a hospital states that they are not ready to treat a cord prolapse, or nonreassuring fetal heart tones, or a maternal stroke, then they are not equipped to be performing any birth.

ACOG also states "*a successful VBAC has the following benefits: No abdominal surgery, shorter recovery period, lower risk of infection, less blood loss. Many women would like to have the experience of vaginal birth, and when successful, VBAC allows this to happen. For women planning to have more children, VBAC may help them avoid certain health problems linked to multiple cesarean deliveries. These problems can include bowel or bladder injury, hysterectomy, and problems with the placenta in future pregnancies. If you know that you want more children, this may figure into your decision.*"

How can we square this strong, compelling statement from ACOG with the fact that approximately 16% of people having a TOLAC in hospitals in Maryland achieve a VBAC (albeit without the corresponding maternal or infant health outcomes that the state has deemed not important enough to track, yet consider it so dangerous as to totally restrict access), while 60-80% of VBAC attempts are reported to be successful and safe for mother and child in the home or birth center setting?

Certified Professional Midwives in the State of Maryland are highly trained in out-of-hospital birth, a qualification that we must prove by virtue of the Maryland direct-entry midwifery licensure requirements which are more stringent than many other states' requirements for midwifery licensure, some of which allow VBAC in the out-of-hospital setting with CPMs.

Certified Professional Midwives who are qualified to be licensed in Maryland receive specific training in VBAC and in recognizing conditions that are deemed to be less safe for VBAC in the out-of-hospital setting, including assessing each individual for safety such as type of scar and pregnancy interval, and also trained to prevent, identify and treat the rare emergent situations such as uterine rupture. Uterine rupture, at a rate of 1%, is a much more infrequent occurrence than two other emergency complications; postpartum hemorrhage (3%) and neonatal resuscitation (5-10%), both of which are time-sensitive acute emergencies that CPMs are also well-trained to manage in the home setting, and which we are entrusted to manage under Maryland law.

CPMs are also recognized experts in providing informed choice information and communication to their clients. Healthcare consumers such as pregnant women also must be given the right to choose what is best for them, their babies and their bodies, and with Virginia and DC sitting nearby, currently giving consumers this informed choice to access out-of-hospital VBAC, along with many other states (see the Virginia informed choice document attached) it feels especially arbitrary for Maryland to have set such a state-wise boundary on a condition that has a very low rate of emergency complication and a high rate of safety and success globally. I have attached my VBAC informed choice document as an example of the information that out-of-hospital midwives provide to clients to help them make the right choice for themselves.

I am not writing to you for financial gain; I do not need the business of VBAC hopefuls as am fully booked with clients who wish to have a homebirth for myriad other reasons, usually related to their deep dissatisfaction with their prior or current hospital-based experiences. I am writing to you as someone who sees and feels the trauma and desperation of people who wish to not be forced to gamble with their uteruses and the health of their future pregnancies with their extremely low chances of achieving VBAC in Maryland hospitals. Thank you for your time.

Sincerely,

Nikki Williams

nikki@bedheadbirth.com • www.bedheadbirth.com

Mobile: 443-857-2412 Fax: 833-356-2456

13922 Penn Shop Road, Mt. Airy, MD 21771

6b - X - SB 376 - FIN - MBON - LOSWA.docx.pdf
Uploaded by: Maryland State of
Position: FWA

Maryland

Board of Nursing

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

February 28, 2023

The Honorable Melony Griffith
Chair, Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, MD 21401-1991

RE: SB 376 – Health Occupations – Licensed Direct–Entry Midwives – Previous Cesarean Section – Letter of Support with Amendments

Dear Chair Griffith and Committee Members:

The Maryland Board of Nursing (the Board) respectfully submits this letter of support with amendments for Senate Bill (SB) 376 – Health Occupations – Licensed Direct–Entry Midwives – Previous Cesarean Section. This bill allows a licensed direct–entry midwife to assume and take responsibility for a client who had a previous cesarean section and regulates the circumstances under which the responsibility may be assumed or taken; alters the required contents of a certain informed consent agreement; and requires the State Board of Nursing, in consultation with certain stakeholders, to develop a transport protocol for clients who had a previous cesarean section.

Licensed direct–entry midwives are revered proponents for delivering low–risk midwifery care in communities, particularly in the home setting. LDEMs are independent practitioners educated in the discipline of midwifery through self–study, apprenticeship, or by attending a Board approved midwifery program. The direct–entry midwifery profession has been a formalized license in the state of Maryland since 2015, and has gained familiarity within the healthcare community.

The public health emergency brought many challenges to the healthcare setting, particularly for midwifery, obstetrical, and gynecologic care. As a result, maternal patients sought midwifery care and developed an interest in pursuing labor and delivery in the comfort of their homes. Even with an increase in demand for midwifery services, direct–entry midwives have been prohibited from caring for women with a history of a previous cesarean section, regardless of when the procedure was performed.

On October 31, 2021, the Direct–Entry Midwife Advisory Committee (DMAC) completed a full study regarding the provisions of House Bill (HB) 1032 introduced during the 2021 legislative session, which would have expanded the scope of licensed direct–entry midwives to include providing vaginal birth after cesarean (VBAC) services to qualifying women in Maryland. As part of this report, the committee reviewed the scope of practice for certified professional midwives (statutorily known as licensed–direct entry midwives in the state) permitted to provide

VBAC in other states. Of the thirty–six (36) states with licensure for the legal practice of CPMs, twenty eight (28) allow licensed midwives to attend vaginal births after cesarean, including Virginia and the District of Columbia. The earliest statutory authorities that permitted LDEMs to perform VBAC services were cited by the states of New Mexico (1978) and Louisiana (1985).

Cesarean sections are the most common obstetric procedure that is performed when a vaginal delivery would place the fetus or mother at risk of harm. Due to the invasive nature of this surgery, complications may arise for subsequent pregnancies and trials of labor. One such complication, cited by the American College of Obstetricians and Gynecologists, would include uterine rupture. The incidence of a uterine rupture, however, for an individual with a confirmed low transverse incision could be between 0.2 and 1.5%.[1]

The Board believes that, when provided with full informed consent, the decision of the place and provider of birth should be left to the birthing mother and family. The Board believes it is critical to provide a consent agreement to a patient that informs them of the benefits, risks, and alternatives to the procedure being performed. Additionally, the Board respectfully submits the following amendment in an effort to explicitly state that there is an exception to the prohibition that a LDEM not care for a patient who has had previous uterine surgery.

Amendment #1. On page 1. Section 8 – 6C – 03. Line 25.

A. A licensed direct – entry midwife may not assume or continue to take responsibility…

Amendment #2. On page 2. Section 8 – 6C – 03. Lines 6 – 9.

(11) **EXCEPT AS PROVIDED IN SUBSECTION B, [P] p**revious uterine surgery, including **[:] A CESAREAN SECTION OR MYOMECTOMY;**

B. SUBSECTION A(11) DOES NOT APPLY TO A PATIENT WHO HAD A SINGLE PREVIOUS CESAREAN SECTION THAT:

(i) RESULTED IN THE PATIENT HAVING A CONFIRMED LOW TRANSVERSE INVISION; AND

(ii) WAS PERFORMED AT LEAST 18 MONTHS BEFORE THE EXPECTED DATE OF BIRTH FOR THE CURRENT PREGNANCY.

Amendment #3. On page 3. Section 8 – 6C – 09. Lines 26 – 28.

(1) A DESCRIPTION OF THE PROCEDURE, BENEFITS, ALTERNATIVES, AND RISKS OF A HOME BIRTH AFTER CESAREAN SECTION, INCLUDING CONDITIONS THAT MAY ARISE DURING DELIVERY; AND

[1] Kan A. (2020). Classical Cesarean Section. Surgery journal (New York, N.Y.), 6(Suppl 2), S98–S103. https://doi.org/10.1055/s-0039-3402072

For the reasons discussed above, the Maryland Board of Nursing respectfully submits this letter of support with amendments for SB 376.

I hope this information is useful. For more information, please contact Ms. Iman Farid, Health Planning and Development Administrator, at iman.farid@maryland.gov or Ms. Rhonda Scott, Deputy Director, at (410) 585 – 1953 (rhonda.scott2@maryland.gov).

Sincerely,

Gary N. Hicks
Board President

The opinion of the Board expressed in this document does not necessarily reflect that of the Department of Health or the Administration.

Direct Entry Midwives MPSC - SB 376.pdf
Uploaded by: Adriane Burgess
Position: UNF

6820 Deerpath Road
Elkridge, MD 21075

MARYLAND Patient Safety CENTER

410.540.9210 (Phone)
410.540.9139 (Fax)

February 28, 2023

To: The Honorable Melony Griffith, Chair, Senate Finance Committee

Re: Letter of Concern- Senate Bill 376 - Health Occupations - Licensed Direct-Entry Midwives - Previous Cesarean Section

Dear Chair Griffith:

I am writing to provide feedback on Senate Bill 376 regarding the practice expansion for licensed direct-entry midwives. Specifically, my comments address the proposal to allow direct-entry midwives to provide management of trial of labor and vaginal delivery at home for women who have had a previous c-section.

The Maryland Patient Safety Center has worked diligently over the past 17 years to improve the safety of healthcare in our state. We have led collaboratives to improve all aspects of healthcare safety, including those involving pregnancy, delivery, and newborn care. Our c-section collaborative was successful in reducing – and maintaining reduction in- primary c-sections for Maryland women. Our neonatal abstinence syndrome (NAS) collaborative was successful in reducing transfer of babies with NAS to a higher level of care, allowing them to stay with their mothers. Currently, we are leading the statewide implementation of B.I.R.T.H. Equity Maryland with the aim of eliminating disparities and preventable maternal morbidity and mortality by educating non-obstetric providers on the impact of bias and urgent maternal warning signs.

As the Director of Perinatal and Neonatal Quality and Patient Safety at the Maryland Patient Safety Center and a doctorally prepared registered nurse with over 25 years' experience I am passionate about advocating for the provision of safe care for birthing people. Recognizing the increasing rates of severe maternal morbidity and mortality, and the significant disparities in outcomes that exist, the Maryland Patient Safety Center created my position so that as an organization we can focus on supporting and creating systems of safe care for birthing people in the State of Maryland. I have significant concern over the safety of offering a trial of labor and vaginal birth after c-section (VBAC) at home and therefore I feel it necessary to voice my concern over the potential increase in avoidable neonatal and maternal harm that might result.

As an organization, we support birthing people's right to make an informed decision about their delivery, and believe planned home births can be carried out safely among low-risk women. However, a history of c-section is considered a high-risk factor. A trial of labor after cesarean increases a birthing person's risk of uterine rupture and other complications which are unpredictable, this is why the American College of Obstetricians and Gynecologists (2017) has stated that prior cesarean deliveries are an "absolute contraindication to planned home birth". Subsequently, as the Director of Perinatal and Neonatal Quality and Patient Safety at the state-designated patient safety center, I do not endorse Senate Bill 376 to allow direct-entry midwives

to manage a trial of labor and vaginal delivery at home for women who have had a previous c-section. Nor would I endorse this practice by any other practitioner.

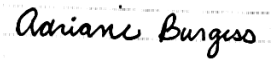
A (2015) study by Cox et al. found that women attempting home VBAC were significantly more often transferred to the hospital than those who did not have a prior cesarean (18% vs 7%, $p < 0.001$). Additionally, women with a prior cesarean who had a home birth had a higher proportion of blood loss, maternal postpartum infections, uterine rupture, and neonatal intensive care unit admissions than those without a prior cesarean. In this study, five neonatal deaths (4.75/1,000) occurred in the prior cesarean group compared with 1.24/1,000 in multiparas without a history of cesarean ($p = 0.015$). Although other studies may support that some birthing people may be eligible for planned home birth after c-section, determining which patients with a history of c-section are most at risk for complications remains challenging. Subsequently, it is safest to proceed with a trial of labor after c-section in a hospital setting where there is immediate access to emergent cesarean section if necessary.

The rate of spontaneous rupture of the uterus after a trial of labor is approximately .5-.9%. Although rare, consequences can be devasting. Spontaneous rupture of the uterus during labor, requires an emergency c-section to save the life of the baby and possibly the mother. In these cases, time is of the essence, and a delay of more than a few minutes to deliver the baby and address any maternal hemorrhage which resulted from the rupture can be devastating. That is why I believe, a trial of labor after cesarean should occur only at a hospital with the resources required for emergency c-section – an obstetrician, and anesthesiologist, a trained operating room staff on site and ready to proceed, and the facilities, equipment, and supplies (most importantly blood for transfusion) immediately available. Obviously, these resources are not available in the home – the time it takes to transfer to a hospital that can manage this event may result in the death of both mother and baby.

To ensure access to safe and respectful maternity care, which promotes access to trial of labor after cesarean and VBAC, legislators should instead focus on developing policies which support hospital VBAC, promotes collaboration between direct entry midwives and hospital providers so that women across the state can easily access VBAC in the hospital setting with the support of their direct entry midwife.

Thank you for allowing me the opportunity to express my concerns regarding Senate Bill 376.

Sincerely,



Adriane Burgess PhD, RNC-OB, CCE, C-ONQS, CPHQ
Director of Perinatal and Neonatal Quality and Patient Safety
Maryland Patient Safety Center
6820 Deerpath Rd, Elkridge, MD 21075
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Committee Opinion No. 697: Planned Home Birth. Obstetrics & Gynecology 129(4):p e117-e122, April 2017. | DOI: 10.1097/AOG.0000000000002024

ACOG Practice Bulletin No. 205: Vaginal Birth After Cesarean Delivery. Obstetrics & Gynecology 133(2):p e110-e127, February 2019. | DOI: 10.1097/AOG.0000000000003078

Cox, K. J., Bovbjerg, M. L., Cheyney, M., & Leeman, L. M. (2015). Planned Home VBAC in the United States, 2004-2009: Outcomes, Maternity Care Practices, and Implications for Shared Decision Making. *Birth (Berkeley, Calif.)*, *42*(4), 299–308. https://doi.org/10.1111/birt.12188

2023 SB376 Written Testimony.pdf
Uploaded by: Deborah Brocato
Position: UNF

Opposition Statement SB376

Health Occupations - Licensed Direct-Entry Midwives - Previous Cesarean Section

Deborah Brocato, Legislative Consultant
Maryland Right to Life

We Oppose SB376

On behalf of our 200,000 followers across the state, we respectfully object to SB376. Maryland Right to Life opposes the expansion of healthcare occupations permitted to promote and provide abortions as extended to midwives in this bill. Pregnancies for post-cesarean women and girls are considered high risk due to the scarring of the organs and tissues surrounding the uterus and the weakened uterine wall as a result of the surgical incision. Risks include uterine rupture, placenta abruption, placenta previa and placenta accreta. The Abortion Care Access Act of 2022 lowered the quality of medical care for women and girls in Maryland. This bill removes a level of safety for post-cesarean women and girls with the transferral of care to a non-physician. An abortion post-cesarean presents further risk of injury especially when done by a non-physician.

Patients before Profits: Broadening the scope of practice for health occupations places profits over patients. Maryland Right to Life (MDRTL) opposes the introduction or passage of any bill expanding the scope of practice of any healthcare professional without language excluding abortion. Medical and surgical abortions carry serious risk of injury up to and including death. For the abortion industry, increasing the number of people who can provide abortion increases the number of abortions thereby increasing income. Thus, the strategy of the abortion industry is to expand scope of practice which allows more individuals to provide medical and surgical abortions. This strategy increases the number of unborn children being killed and puts more women and girls at risk of injury and death.

The medical scarcity in abortion is a matter of medical ethics not provider scarcity, as 9 out of 10 OB/Gyns refuse to commit abortions because they recognize the scientific truth that a human fetus is a living human being. The abortion industry's response to this shortage of willing physicians is to seek authorization for lower-skilled workers and non-physicians to perform abortion, and authorization for abortionists to remotely prescribe abortion pills across state lines.

The women and girls of Maryland deserve better than these lowered safety standards. Maryland Right to Life urges the addition of an amendment to exclude abortion purposes, including the prescription and distribution of chemical abortion drugs from the application of this bill.

For these reasons and without an amendment excluding abortion services, we ask for an unfavorable report on **SB376.**

Grunebaum et al. Infant death- highlighted.pdf
Uploaded by: Jane Krienke
Position: UNF

PLOS ONE

RESEARCH ARTICLE

Serious adverse neonatal outcomes such as 5-minute Apgar score of zero and seizures or severe neurologic dysfunction are increased in planned home births after cesarean delivery

Amos Grünebaum[1]*, Laurence B. McCullough[1], Birgit Arabin[2,3], Frank A. Chervenak[1]

1 Department of Obstetrics and Gynecology, Weill Cornell Medicine, New York, New York, United States of America, **2** Center for Mother and Child, Philipps University, Marburg, Germany, **3** Clara Angela Foundation, Berlin, Germany

* amg2002@med.cornell.edu

Citation: Grünebaum A, McCullough LB, Arabin B, Chervenak FA (2017) Serious adverse neonatal outcomes such as 5-minute Apgar score of zero and seizures or severe neurologic dysfunction are increased in planned home births after cesarean delivery. PLoS ONE 12(3): e0173952. https://doi.org/10.1371/journal.pone.0173952

Editor: Ruth Landau, University of Washington, UNITED STATES

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Data Availability Statement: Data are publicly available and downloadable from the CDC Vital statistics birth data files at: https://www.cdc.gov/nchs/data_access/vitalstatsonline.htm. The authors had no special access privileges to the data and other researchers will be able to access the data by the same means the authors did. No specific requests to the CDC are needed as these are public data available to anyone.

Abstract

The United States is with 37,451 home births in 2014 the country with the largest absolute number of home births among all developed countries. The purpose of this study was to examine the occurrence and risks of a 5-minute Apgar score of zero and neonatal seizures or serious neurologic dysfunction in women with a history of prior cesarean delivery for planned home vaginal birth after cesarean (VBAC), compared to hospital VBAC and hospital birth cesarean deliveries for term normal weight infants in the United States from 2007–2014. We report in this study outcomes of women who had one or more prior cesarean deliveries and included women who had a successful vaginal birth after a trial of labor after cesarean (TOLAC) at home and in the hospital, and a repeat cesarean delivery in the hospital. We excluded preterm births (<37 weeks) and infants weighing under 2500 g. Hospital VBACS were the reference. Women with a planned home birth VBAC had an approximately 10-fold and higher increase in adverse neonatal outcomes when compared to hospital VBACS and hospital repeat cesarean deliveries, a significantly higher incidence and risk of a 5-minute Apgar score of 0 of 1 in 890 (11.24/10,000, relative risk 9.04, 95% confidence interval 4–20.39, p<.0001) and an incidence of neonatal seizures or severe neurologic dysfunction of 1 in 814 (Incidence: 12.27/10,000, relative risk 11.19, 95% confidence interval 5.13–24.29, p<.0001). Because of the significantly increased neonatal risks, obstetric providers should therefore not offer or perform planned home TOLACs and for those desiring a VBAC should strongly recommend a planned TOLAC in the appropriate hospital setting. We emphasize that this stance should be accompanied by effective efforts to make TOLAC available in the appropriate hospital setting.

Funding: The authors received no specific funding for this work.

Competing interests: The authors have declared that no competing interests exist.

Background and objectives

Out-of-hospital (OOH) births in the United States (US) are births occurring outside the hospital and include home and birth center births. OOH births increased from 2009 to 2014 by 80.2% from 32,596 to 58,743 (0.79%-1.47% of all live births).[1] Home births (HB), which are part of OOH births increased by 77.3% [1] from 2009–2014 thus making the US with 37,451 home births in 2014 the country with the largest absolute number of home births among all developed countries, surpassing the approximate 28,000 home births per year in the Netherlands, where home births have decreased over the last decades, though the proportion of home births in the Netherlands is still higher.[2] Despite the American College of Obstetricians and Gynecologists' (ACOG) statement that because of it's increased risk a prior cesarean delivery is a contraindication for a home birth,[3] about 1 in 23 home births in the US are women with prior cesarean delivery.[4]

The purpose of this study was to examine the occurrence and risks of a 5-minute Apgar score of zero and neonatal seizures or serious neurologic dysfunction in all women with a history of prior cesarean delivery for planned home birth VBAC, hospital VBAC and hospital birth cesarean deliveries for term normal weight infants in the United States from 2007–2014.

Materials and methods

This is a retrospective cohort study. Data were obtained from the National Center for Health Statistics (NCHS) of the US Centers for Disease Control (CDC) birth certificate data for 2007–2014. The CDC files contain detailed information on each of the approximately 4 million births in the United States each year. Data on patient characteristics include birth setting and method of delivery as well as whether a home birth was intended or not as reported on birth certificates filed each year with the states of the United States and compiled by NCHS. These data are publicly accessible on the internet (http://205.207.175.93/vitalstats/ReportFolders/ReportFolders.aspx), where detailed tables can be created and downloaded for further evaluation.

The data that we report in this study are for the 2007–2014 period of women who had one or more prior cesarean deliveries and included women who had a successful vaginal birth after a trial of labor after cesarean (TOLAC) at home and in the hospital, a planned repeat cesarean delivery in the hospital, as well as a repeat cesarean delivery after a failed trial of labor after cesarean (TOLAC) in the hospital. We excluded preterm births ($<$37 weeks) and infants weighing under 2500 g. This study therefore includes only term births (deliveries $\geq$37 weeks) and infants weighing $\geq$2500 g.

The home birth variable on the Standard Certificate of a Live Birth distinguishes between an intended (planned) and a non-intended (unplanned) home birth and therefore encompasses "carefully planned home births with emergency unplanned home births".[5] We included only the variables in the birth certificate that indicated planned (intended) home births "carefully planned home births "in this study.

We included outcome data on a 5-minute Apgar scores which are well reported on birth certificates, the clinical and prognostic utility of which is well established.[6,7,8] We also included outcome data on neonatal seizures or serious neurologic dysfunction, the category used by the CDC on birth certificate data. The CDC defines a seizure as "any involuntary repetitive, convulsive movement or behavior." A serious neurologic dysfunction is defined by the CDC as "severe alteration of alertness such as obtundation, stupor, or coma, i.e., hypoxic-ischemic encephalopathy. Excludes lethargy or hypotonia in the absence of other neurologic findings. Exclude symptoms associated with CNS congenital anomalies." (http://www.cdc.gov/nchs/data/dvs/facwksBF04.pdf last accessed June 8, 2016) Five-minute Apgar score of zero and

Table 1. Patient characteristics: Hospital repeat cesarean, hospital VBAC and planned home VBAC for 2014.

Characteristics	Hospital Repeat CS	Hospital VBAC	Home VBAC
	N = 418,004	N = 52,946	N = 1,253
Maternal Race/Ethnicity			
Non-Hispanic white	51.3%	52.8%	88.5%
Non-Hispanic Black	16.7%	15.1%	3.1%
Hispanic	25.6%	23.1%	6.4%
Maternal age (yr)			
<25	16.2%	15.1%	8.8%
25–29	28.1%	29.3%	29.8%
30–34	32.5%	34.0%	38.4%
35–39	18.7%	17.7%	18.2%
>39	4.5%	4.0%	7.1%
Unmarried	34.7%	30.0%	6.5%
Payment			
Medicaid	45.0%	42.1%	10.3%
Private	47.1%	47.7%	18.2%
Self-Pay	3.4%	4.2%	62.9%
Live birth order			
2nd	55.7%	45.8%	27.8%
3rd	28.7%	27.5%	26.2%
4th	10.2%	13.7%	16.0%
Over 4th	5.0%	12.5%	29.5%
Mother foreign born	24.6%	26.8%	6.7%
Birth attendant			
Physician	99.8%	87.1%	1.6%
CNM/CM	0%	12.1%	22.9%
Other midwife	0%	0.3%	55.7%
Other	0.2%	0.5%	18.6%

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data on seizure or serious neurologic dysfunction were calculated for home VBACs (women with prior cesarean deliveries who had a vaginal birth), hospital VBACs, and hospital repeat cesarean deliveries. Hospital VBACs served as the reference group. All statistical analyses were conducted in OpenEpi.[9]

Statistics

Because non-identifiable data from a publicly available dataset were used, our study was not considered human subjects research and did not require review by the institutional review board of Weill Medical College of Cornell University.

Results

Table 1 shows patient characteristics of planned home VBACs as compared to hospital births for 2014. As in prior studies of planned home births, patients with a planned home VBAC were significantly more likely to be non-Hispanic white, ≥30 years of age, US born, and self-pay.

Women with a planned home birth VBAC had an approximately 10-fold and higher increase in adverse neonatal outcomes when compared to hospital VBACS and hospital cesarean deliveries. Table 2 shows the 5-minute Apgar score of zero and seizures or neurologic

Table 2. 5-minute Apgar score of zero and seizures or severe neurologic dysfunction in home birth VBACs versus hospital VBACs and hospital repeat cesarean deliveries 2007–2013.

Cohort	n/total	Reciprocals (per 10,000)	RR [95% CI]	P
5-Min Apgar = 0				
Planned Home Birth VBAC	7/6,229	1 in 890 (11.24)	9.04 [4–20.39]	< .0001
Hospital Repeat Cesarean Delivery	241/2,575,044	1 in 10,685 (0.94)	0.75 [0.53–1.08]	.121
Hospital VBAC	34/273,522	1 in 8,045 (1.24)	1	
Seizures or Neurologic Dysfunction				
Planned Home Birth VBAC	8/6,510	1 in 814 (12.27)	11.2 [5.14–24.42]	<.0001
Hospital Repeat Cesarean Delivery	342/2,574,128	1 in 7,527 (1.33)	1.21 [0.83–1.76]	.315
Hospital VBAC	30/273,401	1 in 9,113 (1.10)	1	

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dysfunction for the 3 groups. Planned home VBACs had a significantly higher incidence and risk of a 5-minute Apgar score of 0 of 1 in 890 (11.24/10,000, relative risk 9.04, 95% confidence interval 4–20.39, p<.0001) and an incidence of neonatal seizures or severe neurologic dysfunction of 1 in 814 (Incidence: 12.27/10,000, relative risk 11.19, 95% confidence interval 5.13–24.29, p<.0001) when compared to hospital VBACs. Hospital delivery VBACs were associated with non-significant increase in 5-minute Apgar of 0 and a non-significant decrease in neonatal seizures when compared to hospital repeat cesarean deliveries.

Comments

Principal findings

Our study shows that a planned home vaginal delivery of a woman with a prior cesarean delivery is associated with a significantly and markedly increased neonatal risk of a 5-minute Apgar score of 0, and neonatal seizures or serious neurologic dysfunction when compared to hospital deliveries of women with prior cesarean deliveries, either VBACs or repeat cesarean delivery.

Clinical implications

According to the American College of Obstetricians and Gynecologists, a low 5-minute Apgar score may be one of the first indications of encephalopathy,[10,11] correlates with neonatal mortality in large populations,[12] and clearly confers an increased relative risk of cerebral palsy, reported to be as high as 20-fold to 100-fold over that of infants with a 5-minute Apgar score of 7–10.[10,13,14,15,16]

A successful trial of labor after prior cesarean delivery (TOLAC) has several potential health advantages for pregnant women. Women who have a successful TOLAC with a VBAC avoid major abdominal surgery, have lower rates of hemorrhage and infection, experience a shorter recovery period, and may avoid potential future maternal consequences of multiple cesarean deliveries such as hysterectomy, bowel or bladder injury, transfusion, infection, and abnormal placentation such as placenta previa and placenta accreta.[17]

Obstetricians and other concerned professionals should understand, identify, and correct the reasons why women with prior cesareans want to deliver at home. Hospitals should create a strong culture of safety with the lowest possible risks. In addition, they should attempt to create an environment committed to fewer unnecessary interventions such as preventing first-time cesarean deliveries, and help women experience a more home-birth-like delivery.[18,19,20,21,22]

The absolute risk for uterine rupture in women undergoing (TOLAC) has been reported to be between 0.5 and 4% or between 1 in 200 to 1 in 25,[23,24] and a trial of labor after prior

cesarean delivery in the hospital is associated with a greater perinatal risk than is elective repeat cesarean delivery without labor.[25]

Because of lower maternal risks, ACOG recommends that women should be offered a TOLAC and that it should be undertaken only in facilities capable of providing emergency care.[3] ACOG classifies a prior cesarean delivery as a contraindication for a home birth because of the risks associated with a TOLAC, such as the unpredictability of uterine rupture and other complications, and because there is no access to immediate expert neonatal resuscitation.[3] The majority of neonatal hypoxic ischemic encephalopathy in patients with TOLAC occur after rupture of the uterus [3] which can be diagnosed with electronic fetal monitoring and can be best managed with expeditious access to all required personnel, anesthesia care, and an operating room, none of which are available with home births.

Our study showing that planned home VBAC is associated with a significantly and markedly increased risk of a 5-minute Apgar score of zero and neonatal seizures or serious neurologic dysfunction has important implications for the informed consent process for planned out-of-hospital birth. In the ethics and law of informed consent, obstetricians have the professional responsibility to identify medically reasonable alternatives for the management of pregnancy and their benefits and risks.[26] Though a TOLAC and successful VBAC is preferable for maternal benefits, in the context of reducing avoidable neonatal risk, the data reported here strongly support the recommendation that planned home TOLAC may not be medically reasonable, as it may result in serious avoidable neonatal complications, given the preventable, clinically significant absolute and relative risks of adverse perinatal outcomes.

Obstetric providers should therefore not offer or perform planned home TOLACs and for those desiring a VBAC should strongly recommend a planned TOLAC in the appropriate hospital setting.[26,27] We emphasize that this stance should be accompanied by effective efforts to make TOLAC available in the appropriate hospital setting.

Strength and weakness

The major strength of our analysis is the large sample size for both hospital and home birth over an 8-year period from the most comprehensive and reliable dataset available in the United States.

Our study has several limitations. The quality of data reported in birth certificates can vary, [5,6,7] though most of the data we used is considered to be reliable. Although information on setting, birth attendant, and Apgar scores is reliable in the CDC dataset, data on seizures or serious neurologic dysfunction are less so,[6,7,8] Not all states participate in the birth certificate data, so their applicability to all US states is not proven. For the states reporting, there was a 97.5% compliance rate for indicating presence or absence of seizures or serious neurologic dysfunction. The CDC data on seizures or serious neurologic dysfunction include those of genetic and prenatal origin that might not be related to birth setting. Another limitation is that it is not possible to know from the CDC data whether a 5-minute Apgar score of 0 was effectively a stillbirth that occurred antepartum or intrapartum. We do not believe that this limitation changes our major findings because the vast majority of stillbirths delivered in the hospital are known to be antepartum and not intrapartum.[28,29]

Data on long-term follow-up of neonates would be optimal, but the CDC database does not include such information. An Apgar score of 0 indicates that there are no signs of life (no heartbeat, no breathing or movements). Infants with a 5-minute Apgar score of 0 have a significantly increased risk of mortality and if they survive an increased risk of significant morbidity.[30,31] Survival relates directly to the effectiveness of advanced neonatal resuscitation that is severely limited in home births.

The CDC does not categorize on birth certificates as out-of-hospital births those hospital births that resulted from transfer from out-of-hospital settings where there was an intention for out-of-hospital birth. There is no way to assess from the CDC natality data when intended out-of-hospital TOLAC deliveries are transferred to the hospital, making an intention-to-treat analysis impossible. Unsuccessful planned home TOLACs may be transferred to a hospital and may then become a hospital repeat cesarean with likely more adverse neonatal outcomes. Because these adverse outcomes are attributed to hospital births instead of home births, this would likely make planned home TOLAC even more of a risk than stated.

Conclusions and implications

Our study results add to and extend the data on the avoidable, greatly increased neonatal risks of home VBAC. [32] These results should become the basis for development of evidence-based guidelines on planned home births for women with prior cesarean delivery. The American Congress of Obstetricians and Gynecologists as well as the Royal College of Obstetricians and Gynecologists have stated that having a prior cesarean delivery is a contraindication for a planned home birth.[17,18] Midwifery organizations in other countries such as the Netherlands, England, and Australia have also recommended against a planned home TOLAC. The American College of Nurse Midwives (ACNM), citing supposed lack of data on outcomes, has not taken an official position on this issue while the Midwives Alliance of North America (MANA), the American home birth midwifery association, supports planned home TOLAC even though studies show that there is an increased risk to the newborn in home births VBACs.[33,34,35,36,37]

As part of the standard practice of the informed consent process, all obstetric providers must disclose the avoidable increased serious neonatal risks of planned home births after cesarean delivery to all women who express an interest in out-of-hospital TOLAC.[23,24] Providing professional guidance with significant, evidence-based information that a planned home birth TOLAC is contraindicated will enhance women's autonomous decision-making.

Author Contributions

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Investigation: AG LM BA FC.

Methodology: AG LM BA FC.

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Visualization: AG LM BA FC.

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Planned Home Birth Need for Additional Contraindic

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OBSTETRICS

Planned home births: the need for additional contraindications

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BACKGROUND: Planned home births in the United States are associated with fewer interventions but with increased adverse neonatal outcomes such as perinatal and neonatal deaths, neonatal seizures or serious neurologic dysfunction, and low 5-minute Apgar scores. The American College of Obstetricians and Gynecologists' Committee on Obstetric Practice states that, to reduce perinatal death and to improve outcomes at planned home births, strict criteria are necessary to guide the selection of appropriate candidates for planned home birth. The committee lists 3 absolute contraindications for a planned home birth: fetal malpresentation, multiple gestations, and a history of cesarean delivery.

OBJECTIVE: The aim of this study was to evaluate whether there are risk factors that should be considered contraindications to planned home births in addition to the 3 that are listed by the American College of Obstetricians and Gynecologists.

STUDY DESIGN: We conducted a population-based, retrospective cohort study of all term (≥37 weeks gestation), normal weight (≥2500 grams), singleton, nonanomalous births from 2009–2013 using the Centers for Disease Control and Prevention's period-linked birth-infant death files that allowed for identification of intended and unintended home births. We examined neonatal deaths (days 0–27 after birth) across 3 groups (hospital-attended births by certified nurse midwives, hospital-attended births by physicians, and planned home births) for 5 risk factors: 2 of the 3 absolute contraindications to home birth listed by the American College of Obstetricians and Gynecologists (breech presentation and previous cesarean delivery) and 3 additional risk factors (parity [nulliparous and multiparous], maternal age [women <35 and ≥35 years old], and gestational age at delivery [37–40 and ≥41 weeks]).

RESULTS: The overall risk of neonatal death was significantly higher in planned home births (12.1 neonatal death/10,000 deliveries; $P<.001$) compared with hospital births by certified nurse midwives (3.08 neonatal death/10,000 deliveries) or physicians (5.09 neonatal death/10,000 deliveries). Neonatal mortality rates were increased significantly at planned home births, with the following individual risk factors: breech presentation (neonatal mortality rate, 127.52/10.000 births), nulliparous pregnant women (neonatal mortality rate, 22.5/10,000), previous cesarean delivery (18.91/10,000 births), and a gestational age ≥41 weeks (neonatal mortality rate, 17.17/10,000 births). Planned home births with ≥1 of the 5 risk factors had significantly higher neonatal death risks compared with deliveries with none of the risks. Neonatal death risk was further increased when a woman's age of ≥35 years was combined with either a first-time birth or a gestational age of ≥41 weeks.

CONCLUSIONS: In this study, we show 2 risk factors with significantly increased neonatal mortality rates at planned home births in addition to the 3 factors that are listed by the American College of Obstetricians and Gynecologists. These additional risks factors have neonatal mortality rates that are approaching or exceeding those for planned home birth after cesarean delivery: first-time births and a gestational age of ≥ 41 weeks. Therefore, 2 additional risk factors (first-time births and a gestational age of ≥41 weeks) should be added to the 3 absolute contraindications of planned home births that are listed by the American College of Obstetricians and Gynecologists (previous cesarean delivery, malpresentation, multiple gestations) for a total of 5 contraindications for planned home births.

Key words: breech, home birth, maternal age, midwife, neonatal death, parity, previous cesarean delivery

Home births in the United States have increased over the last decade.[1] The 37,551 home births in the United States in 2014 (0.94% of all US births) are now the highest in absolute numbers of all industrialized countries.[1] Planned home births in the United States are associated with fewer interventions[2] but with an increased risk of perinatal and neonatal death[2-4]; a 3-fold increased risk of neonatal seizures or serious neurologic dysfunction[5,6]; an increased risk of 5-minute Apgar score of 0, <7, and <4[2,6]; an increased risk for neonatal death in a breech presenting fetus,[7] and in women with previous cesarean births.[8]

EDITORS' CHOICE

The American College of Obstetricians and Gynecologists' (ACOG) Committee on Obstetric Practice described the safety of planned home births in the United States as controversial.[5] In addition, ACOG states that in order to reduce perinatal mortality at planned home births and achieving favorable home birth outcomes, "…strict criteria are necessary to guide selection of appropriate candidates for planned home birth," and it lists three absolute contraindications for a planned home birth: fetal malpresentation, multiple gestations, and a history of previous cesarean delivery.[5]

The aim of this study was to analyze the association of neonatal death with additional risk factors such as nulliparity, a gestational age ≥ 41 weeks, and women ≥ 35 years of age, and to evaluate whether these risk factors should be considered additional contraindications to planned home birth.

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Materials and Methods

Study population

This is a population-based, retrospective cohort study of all term (≥37 weeks gestation), normal weight (≥2500 g), singleton, nonanomalous births from 2009−2013, the last 5 years of the available data, in states that used the 2003 revised birth certificate and the Centers for Disease Control and Prevention's period-linked birth-infant deaths files that allowed for identification of intended and unintended home births. We excluded births if they met any of the following criteria: birthplace outside the hospital or home; unintended home births; gestational age <37 weeks or not recorded; neonatal birthweight <2500 g or not recorded; multiple gestations; any congenital anomaly, Down syndrome or other chromosomal disorder confirmed or pending; and residents of a foreign country. Multiples births were excluded from the data evaluation because there were too few multiples among planned home births to create meaningful data. The data included the location of deliveries (home vs hospital), the attendant at the delivery, and, for deliveries that occurred at home, whether it was intended or unintended. This analysis included only intended home births; for hospital births, the analysis included those who attended the delivery (physician or midwife). Most deaths are linked to their corresponding birth certificates (approximately 99%); however, the deaths are weighted with the use of the weights that were assigned by the Centers for Disease Control and Prevention to account for unlinked deaths.

Statistical analysis

The dataset was analyzed to examine total neonatal deaths (death of a liveborn neonate between days 0−27 of life) across 3 groups: hospital-attended births by certified nurse midwives, hospital-attended births by physicians, and planned home births.

Descriptive statistics for births and neonatal deaths were calculated separately for midwife-attended and physician-attended hospital births and compared with intended home births with the use of chi-square and Fisher's exact tests with significance set at a probability value of <.05.

We calculated the risk of neonatal death per 10,000 deliveries and the standardized mortality ratio (SMR) for planned home births and physician-attended hospital births vs midwife-attended hospital births using the indirect method that accounted for parity (nulliparous vs multiparous), maternal age (women <35 vs ≥35 years old), and gestational age at delivery (37-40 vs ≥41 weeks gestation).

After restricting the sample to a relatively low-risk set of singleton births that delivered at ≥37 weeks gestation, ≥2500 g, and without congenital anomalies, we selected the most parsimonious set of confounding variables to facilitate the adjusted analysis. We controlled for age, parity, and postterm dates because these were determined a priori to be the strongest predictors for neonatal death.

An SMR >1 indicates that the risk of neonatal death in the study population (eg, intended home births or physician-attended hospital births) is higher than expected if the risk of neonatal death were similar to that experienced among midwife-attended hospital births. We also calculated 95% confidence intervals; if the 95% confidence interval did not cross 1.00, the difference in mortality rate was considered statistically significant. The SMRs for 5 risk factors for neonatal death were evaluated: 2 of the 3 absolute contraindications to home birth that are listed by ACOG (breech presentation and previous cesarean delivery) and 3 additional risk factors (parity, maternal age, and gestational age at delivery), as described earlier. We also calculated the risks and SMR for any and none of the aforementioned risk factors and for combinations of parity, maternal age, and gestational age. All data analysis was completed in SAS software (version 9.4; SAS Institute Inc, Cary, NC).

Because nonidentifiable data from a publicly available dataset were used, our study was not considered human subjects research and did not require review by the Weill Medical College of Cornell University Institutional Review Board.

Results

Characteristics

The study population included a total of 12,953,671 singleton, nonanomalous, term (≥37 weeks) deliveries with infants who weighed ≥2500 g who delivered in states that used the 2003 revised birth certificate from 2009−2013 in a hospital or were intended (or planned) home births. Of the whole group, 11,779,659 deliveries (90.9%) were hospital deliveries by physicians; 1,077,197 deliveries (8.3%) were hospital deliveries by certified nurse midwives, and 96,815 deliveries (0.7%) were intended (planned) home births. Of the total of 6467 neonatal deaths, 6015 deaths (93.0%) were hospital deliveries by physicians; 334 deaths (5.2%) were hospital deliveries by certified nurse midwives, and 118 deaths (1.8%) were intended (planned) home births.

Table 1 shows the characteristics of the 3 subgroups for all deliveries and neonatal deaths. Women with planned home births were significantly more likely to be non-Hispanic white, older, parous, self-payers for delivery, or to deliver infants at ≥4000 g and ≥41 weeks of gestational age (postterm). Approximately 1 in 168 planned home births was a breech delivery, and approximately 1 in 23 planned home births was a vaginal birth after cesarean delivery.

Neonatal death

The risk of neonatal death was significantly higher in planned home births (12.1 neonatal deaths/10,000 births; $P<.001$) compared with hospital births by certified nurse midwives (3.08 neonatal deaths/10,000 births) or physicians (5.09 neonatal deaths/10,000 deliveries; Table 2). Women with the highest increased individual risk for neonatal death at planned home births were those with breech presentation (127.52 neonatal death/10.000 births or 1 in 78 breech births), followed by nulliparous women (22.5 neonatal deaths/10,000 births or 1 in 444 first-time births), those with previous cesarean delivery (18.91 neonatal deaths/10,000 births or 1 in 529 births), pregnancies with a gestational age ≥41 weeks (17.17 neonatal deaths/10,000 births or

TABLE 1
Maternal, newborn infant, and delivery characteristics associated with nonanomalous singleton births[a]

Variable	Deliveries (n=12,953,671)				Neonatal deaths (n=6467)			
	Hospital midwife (n=1,077,197), n (%)	Hospital physician (n=11,779,659), n (%)	Intended home birth (n=96,815), n (%)	*P* value[b]	Hospital midwife (n=334), n (%)	Hospital physician (n=6015), n (%)	Intended home births (n=118), n (%)	*P* value[b]
Maternal ethnicity				<.001				<.001
Non-Hispanic								
White	577,665 (53.6)	6,276,662 (53.3)	87,253 (90.1)		188 (56.3)	3176 (52.8)	110 (93.2)	
Black	137,484 (12.8)	1,539,889 (13.1)	1,890 (2.0)		54 (16.2)	1054 (17.5)	0	
Hispanic	283,687 (26.3)	3,042,950 (25.8)	4,643 (4.8)		65 (19.5)	1362 (22.6)	4 (3.4)	
Other	71,335 (6.6)	828,184 (7.0)	1,614 (1.7)		22 (6.6)	332 (5.5)	1 (0.8)	
Unknown	7,026 (0.7)	91,974 (0.8)	1,415 (1.5)		5 (1.5)	90 (1.5)	3 (2.5)	
Maternal age, y				<.001				<.001
<25	390,660 (36.3)	3,745,494 (31.8)	15,294 (15.8)		134 (40.1)	2311 (38.4)	26 (22.0)	
25–34	567,481 (52.7)	6,336,325 (53.8)	61,409 (63.4)		168 (50.3)	2906 (48.3)	64 (54.2)	
≥35	119,030 (11.0)	1,697,022 (14.4)	20,106 (20.8)		32 (9.6)	797 (13.3)	27 (22.9)	
Unknown	26 (0.0)	818 (0.0)	6 (0.0)		0	1 (0.0)	0	
Maternal education, y				<.001				.37
<13	496,538 (46.1)	4,998,057 (42.4)	38,443 (39.7)		173 (51.8)	3122 (51.9)	56 (47.5)	
≥13	566,134 (52.6)	6,642,060 (56.4)	57,729 (59.6)		153 (45.8)	2722 (45.3)	60 (50.8)	
Unknown	14,525 (1.3)	139,542 (1.2)	643 (0.7)		9 (2.7)	172 (2.9)	1 (0.8)	
Prenatal visits, n				<.001				<.001
0	8,839 (0.8)	145,689 (1.2)	2,652 (2.7)		10 (3.0)	228 (3.8)	13 (11.0)	
1–5	49,372 (5.6)	519,504 (4.4)	13,255 (13.7)		20 (6.0)	482 (8.0)	24 (20.3)	
≥6	973,834 (90.4)	10,679,376 (90.7)	79,765 (82.4)		281 (84.1)	4934 (82.0)	78 (66.1)	
Unknown	45,152 (4.2)	435,090 (3.7)	1,143 (1.2)		23 (7.9)	371 (6.2)	3 (2.5)	
Insurance[c]				<.001				<.001
Private	294,262 (27.3)	3,464,544 (29.4)	12,174 (12.6)		71 (21.3)	1346 (22.4)	11 (9.3)	
Government	319,590 (29.7)	3,337,667 (28.3)	6,145 (6.3)		118 (35.3)	2096 (34.8)	4 (3.4)	
Self-pay/other	47,071 (4.4)	423,746 (3.6)	42,808 (44.2)		18 (5.4)	257 (4.3)	67 (56.8)	
Unknown	12,945 (1.2)	89,663 (0.8)	3,055 (3.2)		4 (1.2)	55 (0.9)	4 (3.4)	
Not reported	403,329 (37.4)	4,464,039 (37.9)	32,633 (33.7)		123 (36.8)	2262 (37.6)	31 (26.3)	
Parity				<.001				.25
Nulliparous	424,060 (39.4)	4,756,609 (40.4)	20,125 (20.8)		157 (47.0)	2482 (41.3)	45 (38.1)	
Parous	641,625 (59.6)	6,952,531 (59.0)	75,809 (78.3)		171 (51.2)	3475 (57.8)	70 (59.3)	
Unknown	11,512 (1.1)	70,519 (0.6)	881 (0.9)		6 (1.8)	56 (0.9)	2 (1.7)	
Previous cesarean delivery				<.001				<.01
No	1,048,436 (97.3)	9,961,948 (84.6)	92,199 (95.2)		323 (96.7)	5108 (84.9)	106 (89.8)	
Yes	22,176 (2.1)	1,782,055 (15.1)	4,273 (4.4)		5 (1.5)	867 (14.4)	8 (6.8)	
Unknown	6,585 (0.6)	35,656 (0.3)	343 (0.4)		6 (1.8)	40 (0.7)	4 (3.4)	

Grünebaum et al. Contraindications for planned home births. Am J Obstet Gynecol 2017.

(continued)

TABLE 1
Maternal, newborn infant, and delivery characteristics associated with nonanomalous singleton births[a] *(continued)*

Variable	Deliveries (n=12,953,671)				Neonatal deaths (n=6467)			
	Hospital midwife (n=1,077,197), n (%)	Hospital physician (n=11,779,659), n (%)	Intended home birth (n=96,815), n (%)	*P* value[b]	Hospital midwife (n=334), n (%)	Hospital physician (n=6015), n (%)	Intended home births (n=118), n (%)	*P* value[b]
Newborn weight, g				<.001				<.001
2500–3999	982,994 (91.3)	10,744,142 (92.2)	76,428 (78.9)		318 (95.2)	5560 (92.4)	98 (83.1)	
≥4000	94,203 (8.7)	1,035,517 (8.8)	20,387 (21.1)		16 (4.8)	455 (7.6)	20 (16.9)	
Gestational age, wk				<.001				<.001
37-38	256,151 (23.8)	3,341,327 (28.4)	14,205 (14.7)		93 (27.8)	2261 (37.6)	18 (15.3)	
39-40	606,165 (56.3)	6,645,173 (56.4)	54,232 (56.0)		164 (49.1)	2824 (46.9)	50 (42.4)	
≥41	214,881 (19.9)	1,793,159 (15.2)	28,378 (29.3)		78 (23.4)	930 (15.5)	49 (41.5)	
Presentation				<.001				<.01
Cephalic	1,036,683 (96.2)	10,977,624 (93.2)	93,462 (96.5)		321 (96.1)	5325 (88.5)	105 (89.0)	
Breech	1,921 (0.2)	300,204 (2.5)	553 (0.6)		3 (0.9)	358 (6.0)	7 (5.9)	
Other	11,189 (1.0)	259,162 (2.2)	470 (0.5)		2 (0.6)	170 (2.8)	1 (0.8)	
Unknown	27,404 (2.5)	242,669 (2.1)	2,330 (2.4)		8 (2.4)	162 (2.7)	5 (4.2)	
Risk composite[d]				<.001				.21
No risk present	414,744 (38.5)	3,464,701 (29.4)	37,286 (38.5)		108 (32.3)	1689 (28.1)	28 (23.7)	
Any risk present	637,530 (59.2)	8,124,803 (69.0)	57,831 (59.7)		218 (65.3)	4185 (69.6)	87 (73.7)	
Unknown	24,923 (2.3)	190,155 (1.6)	1,698 (1.8)		8 (2.4)	141 (2.3)	3 (2.5)	

Percent totals may not add up to 100% because of rounding; data were weighted to reflect neonatal deaths that could not be linked to birth certificate, rounded to nearest whole number for presentation in the Table.

[a] At ≥37 weeks gestation and ≥2500 g by place of delivery and attendant; US national data (among states using the 2003 revised birth certificate), 2009–2013, total births: n=12,953,671; neonatal deaths: n=6494; [b] Probability values were calculated with the use of the Chi square test for deliveries and Fisher's exact test for neonatal deaths, which compared planned home births/deaths with hospital midwife-attended births/deaths; [c] Not reported in 2009–2010; [d] Risk composite (age ≥35 years and/or nulliparous and/or postterm, previous cesarean delivery or breech) vs no risk composite (age <35 years, parous, term, no previous cesarean delivery, and cephalic).

Grünebaum et al. Contraindications for planned home births. Am J Obstet Gynecol 2017.

1 in 582 births with a gestational age ≥41 weeks), and women who were ≥35 years old (13.61 neonatal deaths or 1 in 735 births of women ≥35 years of age; Table 3). The difference in risks of neonatal death between women <35 and >35 years old was not so large (11.66 vs 13.61 neonatal deaths per 10,000 births). For those who were >35 years old, the neonatal death risk was below the risk of those with previous cesarean delivery (13.61 neonatal deaths/10,000 births among those ≥35 years of age vs 18.91 neonatal deaths/10,000 births for those with previous cesarean deliveries). Physician-attended hospital births had a higher neonatal mortality rate when compared with midwife-attended hospital births.

Among planned home births, 59.7% of deliveries had ≥1 of the 5 risks. Among midwife- or physician-attended hospital births, the risks were 59.2% and 69.0%, respectively (*P*<.001 for comparison between hospital physicians vs intended home births and hospital midwives vs intended home births). Planned home births with ≥1 of the 5 risk factors had a significantly higher neonatal death risk when compared with deliveries with none of the risk factors (14.96 neonatal deaths/10,000 births with risk factors vs 7.55 neonatal deaths/10,000 births without risk factors; *P*<.001; Table 4).

TABLE 2
Neonatal death risk and standardized mortality ratio estimates for hospital births and intended home births

Variable	Risk of neonatal death (deaths per 10,000 births)	Standardized mortality ratio[a] (95% confidence interval)
Hospital midwife births	3.08	1.00 (reference)
Intended home births	12.1	4.13 (3.38-4.88)
Hospital physician births	5.09	1.66 (1.62-1.71)

[a] Indirectly standardized with the use of maternal age (<35 vs ≥35 years), parity (nulliparous vs parous), and gestational age (37-40 vs ≥ 41 weeks).

Grünebaum et al. Contraindications for planned home births. Am J Obstet Gynecol 2017.

TABLE 3
Standardized mortality ratio estimates for neonatal deaths in intended home births and physician-attended hospital births vs midwife-attended hospital births by individual risk factors

Variable	Risk in midwife hospital births neonatal deaths per 10,000 births (95% confidence interval)	Risk in intended home births neonatal deaths per 10,000 births (95% confidence interval)	Risk in physician hospital births neonatal deaths per 10,000 births (95% confidence interval)	Standardized mortality ratio (95% confidence interval)	
				Planned home birth vs midwife hospital births	Physician vs midwife hospital births
Parity					
Parous	2.66 (2.26–3.06)	9.29 (7.12–11.46)	5.00 (4.83–5.16)	3.49 (2.68–4.30)	1.88 (1.82–1.94)
Nulliparous	3.71 (3.13–4.29)	22.50 (15.95–29.04)	5.22 (5.01–5.42)	6.06 (4.30–7.83)	1.41 (1.35–1.46)
Gestational age, wk					
37–40	2.95 (2.59–3.32)	9.94 (7.57–12.32)	5.07 (4.93–5.21)	3.37 (2.57–4.17)	1.72 (1.67–1.77)
≥41	3.59 (2.79–4.40)	17.17 (12.33–22.0)	5.18 (4.85–5.52)	4.78 (3.43–6.12)	1.44 (1.35–1.54)
Maternal age, y					
<35	3.13 (2.78–3.49)	11.66 (9.23–14.08)	5.16 (5.02–5.30)	3.72 (2.95–4.50)	1.65 (1.60–1.69)
≥35	2.67 (1.73–3.60)	13.61 (8.49–18.74)	4.65 (4.32–4.97)	5.11 (3.19–7.03)	1.74 (1.62–1.87)
Fetal presentation					
Cephalic	3.10 (2.76–3.44)	11.19 (9.05–13.34)	4.85 (4.72–4.98)	3.61 (2.92–4.31)	1.57 (1.52–1.61)
Breech	15.66 (0.00–33.35)	127.52 (34.00–221.04)	11.93 (10.69–13.16)	8.14 (2.17–14.11)	0.76 (0.68–0.84)
Previous cesarean delivery					
No	3.08 (2.75–3.42)	11.46 (9.27–13.64)	5.13 (4.99–5.27)	3.72 (3.01–4.43)	1.66 (1.62–1.71)
Yes	2.27 (0.29–4.25)	18.91 (5.88–31.93)	4.86 (4.54–5.19)	8.33 (2.59–14.07)	2.14 (2.00–2.29)

Grünebaum et al. Contraindications for planned home births. Am J Obstet Gynecol 2017.

The combination of nulliparity and ≥41 weeks gestational age and a woman's age of ≥35 years combined with either of the 2 risk factors of first-time births and a gestational age of ≥41 weeks further increased the neonatal death risk at planned home births (Table 5).

Comment

The results of our study confirm the findings of other studies that show an increased risk of neonatal death in planned home births.[2,4,5] We have demonstrated that 2 risk factors, namely first-time and postterm (≥41 weeks) pregnancies, significantly had increased neonatal mortality rates, approaching or exceeding those for planned home birth after cesarean delivery, 1 of the 3 ACOG absolute contraindications for planned home birth.[5] Therefore, 2 risk factors (first-time births and births at ≥41 weeks gestation), with a woman's age of ≥35 years further increasing neonatal death risk, should be added to the 3 risk factors that are listed by ACOG (previous cesarean delivery, malpresentation, and multiple gestations)[5] to comprise a list of 5, rather than 3, absolute contraindications to planned home births.

Previous studies have reported the reasons that home births in the United States have worse neonatal outcomes, including the location, less well-trained midwives, poor risk selection, and system issues.[3,4] The increased neonatal death risks and adverse outcomes in US planned home births may be more common, because there are increased perinatal risks in US planned home births[5,9] and because selection criteria are not applied broadly.[5,10] The causes of the increased risks of neonatal death in planned home births include neonatal brain damage and infections,[11] which likely are related to the inability to respond to emergent situations at home and a piecemeal approach to training and credentialing of home birth attendants,[10] although the increased risk of neonatal deaths in US home births is related more closely to the location of birth than to the level of professional certification of birth attendants.[12]

It is very difficult to measure the regional collaboration between home birth midwives and hospitals in retrospective data sets or whether a different collaboration between home birth attendants and hospitals can improve outcomes sufficiently enough to improve neonatal outcomes to acceptable levels. In previous articles, we have stated that every woman who starts labor at home and is transferred to a hospital has to be treated with respect on arrival in the hospital.[11,12]

TABLE 4
Standardized mortality ratio estimates for neonatal death in intended home births and physician-attended hospital births vs midwife-attended hospital births by risk composite

Variable	No risk neonatal deaths per 10,000 births (95% confidence interval)	Any risk neonatal deaths per 10,000 births (95% confidence interval)	Standardized mortality ratio (95% confidence interval)	
			No risk	Any risks
Midwife hospital births	2.61 (2.12–3.10)	3.42 (2.96–3.87)	1.00 (Reference)	1.00 (Reference)
Intended home births	7.55 (4.76–10.34)	14.96 (11.81–18.12)	2.89 (1.82–3.96)	4.38 (3.46–5.30)
Physician hospital births	4.87 (4.64–5.11)	5.15 (5.00–5.31)	1.87 (1.78–1.95)	1.51 (1.46–1.55)

Risk composite (age ≥35 years, nulliparous, postterm, previous cesarean delivery, or breech) vs no risk composite (age <35 years, parous, term, no previous cesarean delivery and cephalic).
Grünebaum et al. Contraindications for planned home births. Am J Obstet Gynecol 2017.

Selection of patients for home births by countries with midwife organizations, such in England, Canada and the Netherlands, follows strict selection criteria. For example, the Royal Dutch Organisation of Midwives has defined collaborative guidelines together with obstetricians on how to select and exclude patients for planned home births.[13] Selections criteria usually include the absence of any preexisting disease, a singleton cephalic pregnancy, gestations <41–42 weeks of pregnancy, and spontaneous labor without preterm rupture of membranes.[13] With strict selection criteria of low-risk patients for planned home births outside the United States, perinatal mortality rates were more comparable with those in the hospital.[14-16] Poor selection of candidates for home births was responsible for an increase in neonatal death in planned home births.[17,18]

Even though most other industrialized nations with established planned home births have strict protocols to choose appropriate candidates for planned home births and to exclude those who are at risk, these protocols do not exist in the United States. The American College of Nurse Midwives has no defined guidelines of patient selection for home births in the United States saying that "…guidelines would impact [midwives'] autonomy" and "…might not support midwives if they choose to attend the home birth of a woman with a breech presentation or a twin gestation or a woman who desires a trial of labor after a previous cesarean."[19]

Pregnancies at ≥41 weeks gestation, women who are ≥35 years old, and

TABLE 5
Standardized mortality ratio estimates for neonatal deaths in intended home births vs midwife-attended hospital births by combinations of selected risk factors

Factor A	Factor B	Risk in intended home births neonatal deaths per 10,000 births (95% confidence interval)	Risk in midwife hospital births neonatal deaths per 10,000 births (95% confidence interval)	Standardized mortality ratio[a] (95% confidence interval)
Nulliparous	≥35 Y	52.33 (18.25–86.42)	4.22 (1.48–6.95)	12.41 (4.33–20.49)
Nulliparous	≥41 Wk	40.34 (24.61–56.07)	4.21 (2.93–5.50)	9.57 (5.84–13.30)
Nulliparous	<35 Y	19.71 (13.30–26.12)	3.68 (3.09–4.28)	5.35 (3.61–7.09)
≥41 Wk	≥35 Y	19.89 (8.17–31.60)	4.09 (1.28–6.89)	4.87 (2.00–7.73)
37–40 Wk	≥35 Y	11.19 (5.72–16.66)	2.38 (1.41–3.34)	4.71 (2.41–7.01)
≥41 Wk	<35 Y	16.50 (11.21–21.79)	3.54 (2.70–4.38)	4.66 (3.16–6.15)
Nulliparous	37–40 Wk	14.48 (8.16–20.81)	3.56 (2.91–4.21)	4.07 (2.29–5.84)
≥41 Wk	Parous	10.56 (6.26–14.87)	3.06 (2.05–4.07)	3.45 (2.04–4.85)
Parous	≥35 Y	9.95 (5.37–14.53)	2.32 (1.35–3.28)	4.30 (2.32–6.28)
37–40 Wk	<35 Y	9.61 (6.98–12.24)	3.03 (2.63–3.42)	3.18 (2.31–4.04)
Parous	<35 Y	9.08 (6.62–11.54)	2.72 (2.29–3.16)	3.34 (2.43–4.24)
37–40 Wk	Parous	8.77 (6.27–11.27)	2.58 (2.14–3.01)	3.41 (2.44–4.38)

[a] Risk in intended home births is listed from highest to lowest.
Grünebaum et al. Contraindications for planned home births. Am J Obstet Gynecol 2017.

nulliparous women have an increased risk of neonatal death.[20-25] Older nulliparous women and those who are >1 week past their due date have a higher chance of transfers from a planned home birth to the hospital.[26] In the national prospective cohort study on home births in England, where there are strict selection criteria, nulliparous women had higher transfers from home to the hospital and had poorer neonatal outcomes,[27] which led Buekens and Keirse[28] to recommended that women with their first pregnancies should not deliver at home. Similarly, Nijhuis[29] from the Netherlands recommended that all primiparous women should deliver in the hospital.

The increased neonatal mortality rate of deliveries by physicians in the hospital when compared with certified nurse midwife hospital deliveries, although still significantly lower than neonatal death at intended home births, likely is due to the increased risk profile of pregnant women delivered by physicians and transfers of at risk patients from midwives to physicians in the hospital.

The strength of our study is that we used the linked birth/infant death dataset (period-linked file), which is generally the preferred source for infant and neonatal mortality rates in the United States.[30] There are also limitations in our study: Criticism has been expressed about some of the data collected in birth and death certificates[31]; other investigators believe that the data are reliable, especially with the data used in this study.[32-34] The present US birth certificate data identify the actual location of delivery and the attendant of the birth, and only queries whether deliveries that occurred at home were intended or unintended. Therefore, these data do not allow for documentation of hospital births about their original intent. Our results likely underestimate the actual neonatal mortality rates in home births because the higher adverse neonatal outcomes for patients who are transferred from home to the hospital are counted in the Centers for Disease Control and Prevention–linked data as hospital and not home birth neonatal outcomes.

Our study shows that there are 2 more risk factors with significantly increased neonatal mortality rates among planned home births: primiparous women and pregnancies with a gestational age of ≥41 weeks. These 2 should be added to the 3 absolute contraindications of intended home births listed by ACOG (previous cesarean, malpresentation, multiple gestations).[5] Neonatal death risk was further increased when a woman's age of ≥35 years was combined with either a first-time birth or a gestational age of ≥41 weeks.

Home births in the United States have increased significantly over the last decade.[1] Obstetricians and other concerned professionals should understand, identify, and correct the root causes of the recrudescence of planned home birth. Within hospital settings, they should create not only a strong culture of safety with the lowest possible risks but also an environment committed to fewer interventions such as the prevention of first-time cesarean deliveries[35] and to helping women experience a more home-birth-like delivery.[36-38] ■

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SB 376 Health Occupations - Licensed Direct-Entry

Uploaded by: Jane Krienke

Position: UNF

Maryland
Hospital Association

Senate Bill 376 - Health Occupations - Licensed Direct-Entry Midwives - Previous Cesarean Section

Position: *Oppose*
February 28, 2023
Senate Finance Committee

MHA Position
On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment in opposition of Senate Bill 376.

In 2015, the Maryland General Assembly passed House Bill 9, which offered a path to licensure for direct-entry midwives (DEM). MHA and other stakeholders agreed to restrictions to ensure home births are as safe as possible. One condition was to limit the scope of practice by not including vaginal births after a cesarean section (C-section), also known as VBACs. As a member of the Direct-Entry Midwife Advisory Committee since its inception, MHA respects a woman's autonomy and personal decisions about her health, and strives to ensure safe care for delivering mothers and their babies. We value the work that DEMs provide for low-risk women wanting a home birth. The basis of our opposition is allowing for a home birth after C-section. It is the location, not the provider that is the issue.

The American College of Obstetrics and Gynecologists (ACOG) states prior C-section deliveries are an "absolute contraindication to planned home birth."[1]

Risk of Death for Mom and Baby with Home Birth After C-Section
A trial of labor after a cesarean delivery (TOLAC) is a strategy to reduce the rate of cesarean births.[2] Research indicates TOLAC can reduce maternal morbidity for current and future pregnancies, but a failed TOLAC is associated with higher morbidity than a scheduled repeat C-section.[3] ACOG recommends a TOLAC happen in "facilities with trained staff and the ability to begin an emergency cesarean delivery within a time interval that best incorporates maternal and fetal risks and benefits with the provision of emergency care."[4] A 2017 study found higher rates of poor outcomes for infants born via VBAC in out-of-hospital settings.[5] Uterine rupture, compared with other complications commonly associated with a TOLAC has been shown to correlate with the largest increase in maternal and neonatal morbidity.[6] **The rate of uterine rupture is estimated to be 15 to 30 times higher for women choosing TOLAC compared to a**

[1] The American College of Obstetricians and Gynecologists. (April, 2017). "Planned Home Birth."
[2] Ibid.
[3] Ibid.
[4] Ibid.
[5] Tilden EL, Cheyney M, Guise J-M, et al. (2017). "Vaginal birth After Cesarean: Neonatal Outcomes and United States Birth Setting"
[6] Togioka, B. and Tonismae, T. (July 1, 2021). "Uterine Rupture."

repeat C-section.[7] Although rare, when a uterine rupture occurs, immediate surgical intervention is required to prevent catastrophic harm to mom and baby. Additionally, studies have found higher rates of intrapartum and neonatal death in areas without an integrated system and collaboration with the receiving hospital, which could delay intrapartum transport.[8]

MHA opposes SB 376 because having a VBAC at home is a known risk. There is not enough time to transfer to a hospital in the event of a uterine rupture. The results can result in the death of or significant injury to mom and baby.

Safe Support for TOLAC and VBAC in Hospitals

There is a safe way to have a TOLAC in Maryland. Hospitals across the state allow for TOLACs and VBACs. All but two of Maryland's 32 birthing hospitals allow for TOLACs and VBACs. However, certain resources must be available 24/7, including anesthesiologist, obstetrician, and pediatrician coverage. Some hospitals require 24/7 neonatologist coverage or a surgical assistant or second physician to be available in case a C-section is required. The reason a hospital would not allow for a TOLAC or VBAC is if these resources cannot be provided. These resources are essential for ensuring access to an operating room within minutes if an adverse event, like a uterine rupture, were to occur. Even though the risk of uterine rupture may be low on an individual basis, statewide policy should focus on the population-level where studies have shown a 1% risk of uterine rupture with VBACs.[9]

Additionally, there are patient criteria considered before recommending a TOLAC. Although the exact details vary by hospital, care provider, and patient, common criteria for why a patient might not be recommended for a TOLAC in the hospital include:

- More than two previous C-sections
- Patients who had a C-section less than 18 months prior
- Patients with a prior T-shaped incision or other trans-fundal uterine surgery
- Patients with a contracted pelvis
- Medical or obstetric complications that preclude vaginal delivery
- Patients with a history of previous uterine rupture
- Patients with a history of myomectomy

Need for Collaboration & Improved Data Oversight and Accountability

Many Maryland hospitals employ or credential certified nurse midwives, which supports a cooperative and collaborative relationship. For women laboring with the assistance of a certified nurse midwife in the hospital, an obstetrician and surgical team is available if an adverse event occurs. This critical relationship does not exist between DEMs and hospitals. **When every second counts, having these relationships and immediate access can mean the difference between a catastrophic outcome and a healthy mom and baby.** Additionally, the credentialling process allows for quality review and ongoing professional practice evaluation.

We need to build the relationship between hospitals and DEMs where there is a seamless transfer of care and robust quality review for the low-risk births within the current scope. This relationship does not exist today. The data reporting process for births attended by a DEM are

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[7] Ibid.

[8] The American College of Obstetricians and Gynecologists. (April, 2017). "Planned Home Birth."

[9] Togioka, B. and Tonismae, T. (July 1, 2021). "Uterine Rupture."

self-reported, de-identified and mailed to the Board of Nursing.[10,11] The current data collection process does not provide the transparency and opportunity for case review that we have with other providers attending births in the hospital. More needs to be done to provide oversight, accountability and tracking of this data. There is no way to track individual DEMs who may be transferring a high number of patients or having poor outcomes consistently. More oversight is needed to ensure accountability since DEMs are licensed by the state of Maryland.

Hospitals are available 24/7 to assist in emergencies and help when there are adverse outcomes for home births. It would be unimaginable to expand DEM scope to include such a high-risk birth, especially without quick access to the resources needed to rapidly intervene.

For the safety of birthing mothers and their babies, we strongly recommend an ***unfavorable*** report on SB 376.

For more information, please contact:
Jane Krienke, Senior Legislative Analyst, Government Affairs
Jkrienke@mhaonline.org

[10] Maryland Board of Nursing. (November 16, 2022). "FY 2022 Report from the Committee as Required by Health Occupations Article, Title 8, Section 8-6C-12(a)(10), Annotated Code of Maryland
[11] Maryland Board of Nursing. "Maryland Data Collection Form,".

SB0376_UNF_MedChi, MDACOG_Licensed Direct-Entry Mi
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TO: The Honorable Melony Griffith, Chair
Members, Senate Finance Committee
The Honorable Arthur Ellis

FROM: Pamela Metz Kasemeyer
J. Steven Wise
Danna L. Kauffman
Andrew G. Vetter
Christine K. Krone
410-244-7000

DATE: February 28, 2023

RE: **OPPOSE** – Senate Bill 376 – *Health Occupations – Licensed Direct-Entry Midwives – Previous Cesarean Section*

On behalf of the Maryland State Medical Society and the Maryland Section of the American College of Obstetricians and Gynecologists, we submit this letter of **opposition** for Senate Bill 376.

Senate Bill 376 authorizes Direct-Entry Midwives (DEMs) to preform vaginal births after a cesarean section (VBAC) under certain circumstances. The issue of VBAC being performed by DEMs in the home setting was the subject of significant debate and consideration when the DEMs were originally authorized to practice in Maryland. The significant risk issues associated with VBACs is the basis for the current prohibition.

A prior cesarean delivery is an absolute contraindication to a planned home birth even under limitations reflected in Senate Bill 376. Because of risks associated with a trial of labor after cesarean delivery (TOLAC) and the unpredictability of uterine rupture and other complications, TOLAC should only be undertaken in facilities with trained staff and the ability to begin an emergency cesarean delivery. The National Institutes of Health (NIH) have issued a consensus statement that speaks to the safety and clinical risk issues that makes a TOLAC virtually unacceptable in the home birth setting.

The NIH statement indicates that TOLAC should be undertaken at facilities capable of performing emergency deliveries. Also recommended is continuous electronic fetal monitoring and that a facility must be ready to perform an emergent cesarean delivery. This would necessitate a team consisting of surgeons, anesthesia personnel, surgical nurses, and operating rooms as well as blood transfusions, if needed, and appropriate postoperative care. The lack of these safeguards stresses the importance of precluding the practice of attempting a trial of labor to achieve a VBAC in out of hospital settings. Moreover, if TOLAC was authorized in the home setting and a transfer became necessary, there would be an unacceptable delay in rendering the necessary care as a result of the transfer to a suitable facility coupled with the need for a preoperative evaluation and preparation upon arrival to that facility. Senate Bill 376 poses an unacceptable and unnecessary risk to women who have previously had a cesarean delivery. An unfavorable report is requested.

6a - X - SB 376 - FIN - MDH - LOI.pdf
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Position: INFO

Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

February 28, 2023

The Honorable Melony Griffith
Chair, Finance Committee
3 East Miller Senate Office Building
Annapolis, MD 21401-1991

RE: SB 376 - Health Occupations – Licensed Direct–Entry Midwives – Previous Cesarean Section – Letter of Information

Dear Chair Griffith and Committee Members:

The Maryland Department of Health (MDH) is submitting a letter of information for Senate Bill (SB) 376 - Health Occupations – Licensed Direct–Entry Midwives – Previous Cesarean Section. SB 376 will add a previous cesarean section (c-section; specifically, c-section which resulted in a confirmed low transverse incision and was performed at least 18 months prior to the expected date of birth for the current pregnancy) to the list of conditions that requires a Direct-Entry Midwife to consult with a health-care practitioner and share the recommendations of the consultation with the patient. SB 376 will also require that a Direct-Entry Midwife transfer care to a healthcare practitioner for patients with a history of c-section (except as specified above) or myomectomy (removal of fibroids from the uterus). Lastly, the bill requires that the State Board of Nursing, in consultation with certain stakeholders develop a planned out-of-hospital birth transport protocol for patients with a previous c-section.

The Committee on Obstetric Practice with the American College of Obstetrics and Gynecology (ACOG) considers a prior c-section delivery, fetal malpresentation, or multiple gestation, to be an absolute contraindication to planned home birth.[1] Specifically, for a prior c-section delivery, complications such as uterine rupture may be unpredictable.[2] A recent US study showed that planned home trial of labor after c-section (TOLAC) was associated with intrapartum fetal death rate higher than the rate for a trial of labor at hospitals (2.9 vs. 0.13 per 1,000).[3] ACOG recommends that a TOLAC be undertaken in facilities where there is the ability to begin an emergency c-section delivery within a time interval that best incorporates maternal and fetal risks and benefits with the provision of emergency care due to the risks associated with the trial.

MDH believes it is critical to provide a consent agreement to a patient that informs them of the benefits, risks, and alternatives to the procedure being performed. The decision to offer and pursue a TOLAC in a setting in which the option for immediate c-section delivery is limited should be considered carefully by patients and their health care providers. When provided with full informed consent, the decision of the place and provider of birth should be left to the birthing parent and family.

1. The American College of Obstetrics and Gynecologists.Committee Opinion. Number 697. April 2017. (Reaffirmed 2020). Planned Home Birth. https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2017/04/planned-home-birth.pdf

MDH also notes that many home births result in hospital transfers due to intrapartum or postpartum complications. A review of 15 studies with data from 215,257 women found that 9.9% to 31.9% of home births were transferred to a hospital.[4] In Maryland, there are six counties (Caroline, Dorchester, Kent, Queen Anne's, Somerset, and Worcester) without a birthing hospital within county borders.[5] Two birthing hospitals, Peninsula Regional Medical Center and University of Maryland Shore Health at Easton, are the closest facility for 5 of the 6 jurisdictions (Caroline, Dorchester, Queen Anne's, Somerset, and Worcester), with Union Hospital of Cecil County being the closest facility to Kent County. On average, the distance from these counties to the nearest facility ranges from 18 to 36 miles, but individuals may need to travel farther depending on their location within the county.

The distance from these facilities highlights the importance of an informed consent discussion, so that the patient and family can understand the benefits, risks, and alternatives to the procedure. In that discussion, the patient and health care provider should consider the transport protocol for planned home births including geography, distance, and a timely method to transport to a facility equipped to treat patients transferred in emergency situations.

If you have any questions please contact Megan Peters, Acting Director, Office of Governmental Affairs, megan.peters@maryland.gov or (410) 260-3190.

Sincerely,

Laura Herrera Scott, M.D, M.P.H.
Secretary

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4. Blix E, Kumle M, Kjærgaard H, Øian P, Lindgren HE. Transfer to hospital in planned home births: a systematic review. *BMC Pregnancy Childbirth*. 2014;14:179. Published 2014 May 29. doi:10.1186/1471-2393-14-179
5. https://mdmom.org/birthinghospitals