Birthing Center Comments 10.05.02

Name of Submitter and Organization	Comment(s)	OHCQ Response
Jan Kriebs, ACNM	Via email 5-4-2024: Student nurse midwives hold RN licenses and thus would be eligible to be the second licensed person at a birth center, while neither CM students or CPM students are likely to hold a professional healthcare license, although there are rare CM students who are PAs or foreign trained physicians. Would it be possible for these students to be permitted to be the second person in a birth center at some point in their training? I can't speak for the CPM training. However, I will point out that 1) by the time a student who will be a CM is in clinical courses, they have met the same educational competencies as their RN classmates; and 2) an increasing percentage of student nurse-midwives are coming into midwifery directly from nursing education or with minimal time in nursing. Thank you for considering this!	OHCQ's decision is to not include any new language on students at this time. OHCQ will catalog your comment for future consideration, after seeking input from stakeholders.
ACOG	American College of OB/GYNs are not dramatically opposed to including that language; I just think it is somewhat confusing because I understand there are family medicine doctors that do OB/GYN, but I am not aware where in Family Medicine practice that they are solely doing OB/GYN work and most are not doing that any more, even if they could, because there is such a shortage and they are not willing to take it on. It is more a reaction of an impression from ACOG members that somehow the physician in the OB area has to have a secondary referral when that is not necessary. I do like the suggestion of putting in the fetal monitoring. That makes a lot of sense.	The intent of 10.05.02.08 Consultation could include referrals to social workers or lactation specialists; the intent of 10.05.02.09 Referrals is for patient safety and could include a request to an OB/GYN or neonatologist at a tertiary care facility to accept a patient. In both instances, a Family Practice physician working at a Birthing Center could consult or refer to another physician, so the language will remain unchanged.
Jan Kriebs, American College of Nurse Midwives	I would like to go back to Pam and Christine's comments about removing the word physician, what if it were a Family Medicine physician who does normal obstetrics and who wants to practice in a Birth Center. They might well want to consult with an OB/GYN if a C-section was needed, or there were complications that indicated a transfer to someone other than a another family doctor. This is a question, not an answer.	The intent of 10.05.02.08 Consultation is broad and could include referrals to social workers or lactation specialists; the intent of 10.05.02.09 Referrals is for patient safety and could include a request to an OB/GYN or neonatologist at a tertiary care facility to accept a patient. In both instances, a Family Practice physician working at a Birthing Center could consult or refer to another physician, so the language will remain unchanged.
Jan Kiebs,	Page 11 Protocols, Clinical Practice Guidelines I have spoken to this before, but I strongly want to encourage us to include in the Clinical Practice Guidelines, a procedure that requires fetal heart rate monitoring during labor that meets the standard criteria for fetal monitoring in labor. There is a very good intermittent auscultation program that A1 and ACOG and others support. I would like to see that in the Clinical Practice Guidelines. We here is a Guideline that requires fetal heart rate documentation. When I brought it up before, OHCQ reference notes goes back to ultrasound. I am talking about something else, I am talking about using a hand held Doppler to monitor the heart rate. I will be happy to send the guidelines.	OHCQ has added language to 10.05.02.07 Clinical Practice Guidelines about the need to have guidelines addressing monitoring of fetal heart tones consistent with professional standards. OHCQ used language from the Commission for the Accreditation of Birth Centers.

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Jael Marajh,	I am joining just to hear more about the language and the changes that were being made. I am a student and a para- professional midwife, so just trying to see if there is going to be more inclusive language around certified professional midwives in this new draft.	Thank you for participating in OHCQ's Birthing Center regulation process.
Pam Kasemyer,	I have a question, not so much a comment, but there is obviously a lot of new language in the regulations, almost all of it we are OK with it, with the exception of Christine's comments, some of this we think is not necessary. There are a lot of new sections and we were not sure where they came from, not that we have a problem with them.	OHCQ is in the process of updating several chapters of COMAR including Birthing Centers. Template language will be added, as appropriate, to clarify the enforcement process and protect a facility's right for an informal dispute resolution. OHCQ's authority and processes related to IDRs and enforcement will not change.
Christine Krone, Maryland Section of the American College of Obstetricians & Gynecologists	Page 12, COMAR 10.05.02 09 under Referrals We would request that the original language be retained or a deletion of "physician" where is says that "an LDEM, CM, CNM, and physician shall refer clients". We would like to see it deleted, ideally we would like referrals to go to a physician. Regarding Section a (above section before) "a LDEM, CM, CNM, and physician shall consult". Again, we request "physician" be deleted out of the first line.	The intent of 10.05.02.08 Consultation could include referrals to social workers or lactation specialists; the intent of 10.05.02.09 Referrals is for patient safety and could include a request to an OB/GYN or neonatologist at a tertiary care facility to accept a patient. In both instances, a Family Practice physician working at a Birthing Center could consult or refer to another physician, so the language will remain unchanged.
Caitlin McDonough, Assocation of Independent Midwives of Maryland	Our comments are what we have submitted in the past, although I know OHCQ opted not to change what we requested in the second draft. Our only issue is that the way the regulations are structured now, is the LDEMs cannot practice up to their regular scope that they practice in home births, or any other out-of-institution births. They would have to practice alongside a nurse midwife in every birth and that is not something we have to do with our regular scope. We have to have a second individual that meets certain requirements, but not necessarily be a full midwife. I think the result is that you will have trouble attracting LDEMS if they can't practice to their full scope. Ultimately it is up to the OHCQ. That is our comment for the record.	Language about a non-licensed assistant serving as the second individual attending a birth will not be included in the regulations at this time.
Jan Kriebs, American College of Nurse MIdwives	The early birth centers in Maryland were by in large, in residential areas.	Thank you for participating in OHCQ's Birthing Center regulation process.
Charnise Littles, Birth & Milk Company	Wondering if part of the regulations can state the appropriateness for Freestanding Birth Centers to be found in residential as well as commercial zoning areas within the State of Maryland. In the past, we looked at sites that are homelike, not the hospital setting, but that still had access if transports are needed. Residential locations that would be very good for a Birth Center, are not zoned appropriately for my County, so it is a bit of a struggle. We are asking if the regulations could state the appropriateness of residential zoning for Birth Centers, permitting that all other functions would still be met.	Thank you for participating in OHCQ's Birthing Center regulation process. Please know that zoning laws are not under the purview of OHCQ; therefore language about residential verses commercial location cannot be added to COMAR 10.05.02.