PUBLIC HEALTH DIVISION
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Kate Brown, Governor

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Birthing Center RAC
January 24, 2020
9:00 – Noon; Room 1-E

RAC MEMBER ATTENDEES	
Silke Akerson	Oregon Midwifery Council
Kaylyn Anderson (phone)	Consumer
Karen DeWitt	Oregon Association of Naturopathic Physicians
Laura Erickson	Alma Midwifery Services
Colleen Forbes	Former Chair, Board of Direct Entry Midwives
Jason Gingerich (phone) for Cat Livingston	Health Evidence Review Commission
Hermine Hayes-Klein	Oregon Association of Birthing centers
Desiree LeFave	Bella Vie Birthing center
Meredith Mance	Aurora Birthing center
Samie Patnode (phone)	Board of DEM
Margaret Porter	Bella Vie Birthing center
Alice Taylor (phone)	American Association of Birthing centers
Willa Woodard Ervin (phone)	Rogue Birth Center
Michele Zimmerman-Pike	American College of Nurse Midwives
OTHER INTERESTED PARTY ATTENDEES	
Brooke Bina (phone)	Alma Midwifery Services
Kelley Burnett (phone)	Medical Director, All Care Health
Coleen Connolly (phone)	Medical Director, Trillium Community Health Plan
Debbie Cowart	Growing Family Birthing center
Jody Davis	Public
Dr. Gamble (phone)	Associate Medical Director, All Care Health
Lindsey Lincoln (phone)	Growing Family Birthing center
Kailia Wray (phone)	Midwife

OHA PHD HCRQI Staff	
Mellony Bernal	Admin. Rules and Leg. Policy Analyst; Health Care Reg. & Quality Improvement
Anna Davis	Survey and Certification Manager; Health Facility Licensing & Certification
Rebecca Long	Paramedic/Health Educator; EMS and Trauma Systems
Dana Selover	Section Manager; Health Care Regulation & Quality Improvement

Welcome / Overview
M. Bernal welcomed RAC members and participants introduced themselves.

November 22, 2019 Birthing Center RAC meeting notes
D. Selover asked whether members of the RAC had any comments on the November meeting notes? RAC member submitted clarification to comments made and that were summarized in the minutes. This document is attached and will be appended to the November meeting notes as well. The November meeting notes have been edited to include the following statement: - Clarifying statements for these November minutes were submitted by a RAC member at the January 24, 2020 BC RAC meeting. These comments are attached for reference.
ACTION: November notes will be edited to include the statement noted above and the comments made at this meeting will be attached to both the November meeting notes and these January notes.
Overview – Dana Selover
Dana Selover provided an overview of where the RAC is in the process of these rules. • The rule language has been reviewed by the RAC including several housekeeping changes made for alignment with other licensed facility types. The RAC is now focused on the risk factor tables. • The program is tracking action items from each of the previous RAC meetings and is working on edits based on those action items. At least one future meeting will be designated to review these action items, the programs response to the action item, and any edits made to the rules. • The DEM rules have been completed and were made effective January 1, 2020. • The Health Evidence Review Commission's (HERC), Evidence Based Guidelines Subcommittee (EbGS) last met on December 5, 2019 at which time final proposed edits to the Coverage Guidance for Planned Out-of-Hospital Birth were made. The revised proposed guidance was posted for public comment from December 10, 2019 and closed on January 9, 2020. The EbGS will be reviewing those comments at its meeting on February 6, 2020 and will decide on whether to approve, amend or ask staff to make further changes for consideration. If approved to move to the HERC, the proposed new coverage guidance would be considered at its March 12, 2020 meeting. RAC member remarked that in addition to the birthing center rules, the direct entry midwifery rules and the HERC guidelines, there are additional rule sets that need to be considered including the Board of Naturopathic Examiners and State Board of Nursing rules for Certified Nurse Midwives. Staff acknowledged separate provider rules but noted that the HERC, the Board of DEM and this office are all part of OHA, all three of which have been working on amendments to rules or guidance. RAC member reiterated that regardless purview, the other Boards and the scope of practice rules under each, will be impacted by the Birthing Center rules.

D. Selover noted the following:

- Rules adopted by the Board of DEM include the scope of practice standards for licensed direct entry midwives. These rules include patient interaction, consultation requirements, as well as some risk factor exclusions.
- The HERC guidance is specifically for the Medicaid population for purposes of payment and is driven by the values of safety, benefits versus potential harm, and optimal outcomes.
- As a rule's advisory committee (RAC), recommendations made, and proposed rule language is channeled through legal counsel to ensure that the rules meet the statutory requirements. It is understood that prenatal care and consultation occurs in a birthing center; however, as defined in statute a freestanding birthing center is a facility for the primary purpose of performing low risk deliveries. As such, the program's focus in terms of rules is safety.
    - Rules were initially adopted in 1985 and risk factor tables were adopted in 2006 in order to define what is a low risk birth. The Board of DEM and the HERC have been established since then and have also established low risk birth criteria and as such the program needs to take into consideration this work.
    - The program must also consider the survey teams that must go out and verify compliance using survey tools, functional checklists, record review and interview questions to determine compliance including adequate and appropriate application of the risk factor tables.
    - Despite the scope of practice standards adopted by provider licensing boards, the program has proposed language based on the HERC guidelines because those guidelines are based on low harm, low risk. If changes are needed, a method to justify disagreeing is necessary (data, evidence, national practice guidelines, etc.)
    - Decisions made by the program will not be made in the same manner that the HERC or the Board of DEM does. This program does not have the same framework for evidence-based review as the HERC. As such, in considering changes, the program is seeking information from the RAC for justification for change, including evidence through national guidelines or research articles.

RAC member thanked another RAC member who brought up the different provider type rules and understands that birthing center rules should not be in direct conflict with different provider type rules. However, examples of situations exist where a birthing center benefits from being able to take a patient who was not going to get her OOH birth paid for because with extra consultation, additional assessments, etc. can be safe to deliver OOH. Additional rules should not be added that don't affect safety especially if other measures can be put in place (assessments, consultations, etc.) to make things safe for a well-informed consenting woman.

RAC member remarked that all accredited birthing centers have multiple lists of criteria in place to meet the definition of only low risk birth established by the Commission on Accreditation of Birth Centers.

RAC member commented that based on information provided, it's the term "low risk deliveries" that appears to be the focus and treating risk as an 'on/off switch' to determine which bucket will women fit. RAC member further stated that presumably existing risk factor tables were determined to have met the statutory definition and now the proposal is to redefine rules to make HERC guidance the definition. While laws written must meet the statutory definition of freestanding birthing center, they must not contradict other statutes including that Oregon citizens have a right of informed consent and refusal. RAC member further asserted in response to comment that RAC members provide evidence-based material or guidelines to dispute certain risk factors, that if the Authority is adding risk factors that were not previously identified, then the burden is on OHA to present the data that supports the change. Follow-up from RAC representative: Oregon's statutory right to decision-making is ORS 127.507.

RAC member thanked other RAC members for comments and noted that the different criteria for different providers can be challenging. AABC standards for risk criteria are very brief. Complications that may affect outcomes are how they address risk factors which implies that there should be an integrated system with collaboration, consultation and referral. This RAC is in a unique position to bridge the gap between the HERC guidelines, DEM rules and other standards. RAC member read the following statement from the AABC standards:

> "The birth center respects and facilitates a pregnant person's right to make informed choices about their health care and their baby's health care based on their values and their beliefs."

RAC member further stated that the AABC believes that decisions should be made by licensed providers and the licensed birth center facility, in collaboration with the team – the team being an integrated system. It is a woman's constitutional right to refuse care which supersedes state's rights.

RAC member echoed other RAC member comments that the RAC should remember there are other provider scopes of practice to consider. Each provider type should be trusted to manage the care of a client based on those provider scope of practice laws. Scope of practice should not be managed in a facility setting. Additionally, if rules are going to be more restrictive, clear evidence needs to be provided that shows there is a decrease in safety that moves the criteria from low risk. While birth centers exist for low risk women, from information reported at the last meeting there is no clear line on what is low risk and what is not. VBACs are an example where there are risks both in the birthing center and a hospital setting based on data.

RAC member remarked that when looking at evidence, the RAC must also consider that just because evidence may suggest that there is an increased recurrence of a specific condition, it doesn't mean they are at an increased risk because they select OOH care. What should be looked at is what is the difference in birth site outcomes.

RAC member stated that since the inception of the HERC guidelines, many women on Medicaid have not been able to be served. If the HERC guidelines are adopted, an increased number of women with risk factors may seek to give birth at home by themselves and this should be considered as discussions continue. Women know there are increased risks and sometimes the

risks are very small; these women believe that giving birth in a hospital is a bigger risk. The RAC needs to consider women's rights and make sure that women are not excluded.

Staff remarked that in terms of making decisions about the risk factors, the program is driven by the statutory definition of a freestanding birthing center. If persons are dissatisfied with the definition and any unintended consequences from adopting rules, then they should be actively seeking a statutory change and working to include things such as accreditation language or acknowledging that risk should be defined based on provider scope of practice laws. Staff further noted that it seeks guidance from the Oregon Department of Justice in determining interpretation and compliance with Oregon statute.

RAC member responded that the intent is not to change the statute, but rather to acknowledge that risk is variable and there is no defining line that says yes or no, or on and off.

Staff noted that the reason the HERC guidelines were proposed as the foundation for these rules is not to restrict access as has been suggested in previous meetings. Whether that is an indirect result of that is acknowledged but it is not the program's intent to restrict - it is to follow statute, get expert input during the RAC process, and, to the extent possible, align across the OHA what makes the best sense and guidance received by legal counsel. Considerations are the statute, the multiple provider types, the process, the policy, the documentation for decision making, the risks, and managing the consultation. Managing consultations and how that will look will need to be discussed in the future. The decision maker is not the person who was consulted with but rather part of shared decision making process.

HERC staff shared the draft recommendation relating to consultation.

> 'Consultations may be with 1) a provider (MD/DO or CNM) who has active admitting privileges to manage pregnancy in a hospital and/or 2) appropriate specialty consultation (e.g., maternal-fetal medicine, hepatologist, hematologist, psychiatrist). For infectious conditions such as uncomplicated urinary tract infections or sexually transmitted infections, no consultation is necessary if patient receives appropriate treatment.'

OOH birth guidelines do not differentiate between provider types. Broad coverage criteria apply regardless of provider type. The same criteria apply to an MD or DO attending an OOH birth.

RAC member responded that while HERC applies to all provider types, however, the state saying Medicaid can have Care Oregon that does not allow some provider types to deliver outside of the hospital is effectively applying it differently to different provider types.

RAC member remarked that her birth center does operate differently because they have physicians that are licensed to provide care when there is a history of 3rd and 4th degree tears, etc. They have providers that have privileges with the hospital so it's redundant to consult with themselves. Persons who have not met criteria have been able to be served but with extra consultation. Some risk factors are mitigated through further studies such as extra ultrasounds.

Staff thanked RAC members for their comments. Staff provided an overview of a polling system that will be used using a consensus model decision making tool. The program is trying to gauge where priorities are in terms of risk factors. The poll will consist of the following choices:

- "1" - I can say an enthusiastic yes to the recommendation (or action).
- "2" - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- "3" I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths & weaknesses and need more discussion or more work done.
- "4" I do not fully agree with the recommendation and need to register concern. However, I will not block the recommendation. More discussion is necessary for full support.
- "5" I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

RAC members were asked whether anyone was opposed to revisiting those risk factors discussed at the last meeting. RAC concurred.

Staff provided an overview on how the voting poll devices worked.

Risk Factor Table 1 – Risk Factors for EXCLUSION AT ADMISSION

Maternal History –

Cesarean section ~~or other hysterotomy~~

- November 24th meeting, RAC had requested to defer discussion.
- RAC member requested that these criteria be separated as she would vote differently on each criterion. RAC concurred.
- Poll Results:
  - 0% - I can say an enthusiastic yes to the recommendation (or action).
  - 0% - I find the recommendation acceptable and have no serious objections.
  - 0% - I can live with the recommendation, but I'm not overly enthusiastic.
  - 8% - I do not fully agree with the recommendation and need to register concern.
  - 92% - I do not agree with the recommendation and will actively block its movement.
- Defer for further facilitated discussion.

Other hysterotomy

- Poll Results:
  - 0% - I can say an enthusiastic yes to the recommendation (or action).
  - 45% - I find the recommendation acceptable and have no serious objections.
  - 9% - I can live with the recommendation, but I'm not overly enthusiastic.
  - 27% - I do not fully agree with the recommendation and need to register concern.
  - 18% - I do not agree with the recommendation and will actively block its movement.

RAC member asked how the poll will drive further discussion on the criteria. Staff suggested that if the majority of RAC members agree, then minor discussion may be needed. If there is no agreement or the poll is across the board then more discussion will be necessary. If the majority indicates no agreement with recommendations, the program will consider additional facilitated discussions.

- Discussion:

- RAC member remarked that hysterotomy is a very broad topic and should be included in the list for consultation.
- Additional RAC member concurred.
- Staff asked if this was based on the heterogeneous nature of what can fit under the criteria and should be considered on a case by case basis? RAC concurred.
- Staff asked if there was any national guidance or accreditation that would support. RAC member responded that 1) in agreement with having hysterotomy as a consultation criterion and 2) that the AABC will lean towards consultation on many of the risk factors.
- Staff asked if there are any scope of practice guidance for this topic or if it's part of general practice? RAC member responded that it falls under more general guidance acknowledging that there could be a potential for complications so additional consultation would be sought, surgery notes referenced, size of incision, etc.
- RAC member remarked that under the DEM rules extensive transfundal surgery or para uterine rupture is listed as transfer criteria which defines a more significant uterine surgery. Previous myomectomy is in the consultation criteria.
- Staff asked RAC to consider whether "other hysterotomy" should be moved to consultation criteria or whether additional verbiage is necessary to clarify more extensive procedures such as transfundal surgery. Given the wide variety of providers, RAC member suggested keeping the criteria more general and moving to consultation, and suggested stating "hysterotomy other than cesarean."
- Staff asked if there was any support for adding more specific language for extensive procedures for exclusion. RAC indicated no.
- RAC member concurred with leaving language more general because of the different provider types and stated she does not see any value to adding more specificity.
- RAC member stated that the AABC would agree with more general language.

Eclampsia (eclamptic seizure)

- RAC member wanted to make clear based on November discussion, that this is not referring to a maternal history of preeclampsia rather maternal history of eclamptic seizures. RAC concurred.
- RAC member asked if there was any data on the likelihood of eclamptic seizures occurring again. It was noted that a client with a previous history would get a baseline assessment and would be watched carefully for symptoms. RAC member further asked if a "risk of a risk" is something that should be eliminated? Staff responded that consideration needs to be given not only to the probability that it will happen again, but the possible negative outcomes if it were to occur. It was noted that the HERC requires a transfer for eclampsia, preeclampsia requiring pre-term birth, HELLP syndrome and preexisting or chronic hypertension. RAC member noted that if data suggests that there is a 20% likelihood that a woman with preeclampsia may get it again, that means that 80% of women are excluded

from an OOH birth. It was further noted that many times the fastest way for a woman to get care is through a midwife.

- RAC member noted that if a pregnant woman has a history of eclampsia and she wants midwifery care then an OOH birth consultation or a referral for consultation with a maternal fetal medicine (MFM) specialist is very appropriate. The specialist would also consider what are the chances of this happening again. The MFM or OB consult would also be collaborating with the midwife and would outline things that would already be looked for. RAC member reiterated that many factors will fit under consultation including eclampsia. Based on the consultation the woman could make an informed choice on how to proceed with care.
- RAC member remarked that when looking at factors for excluding care even things that are considered serious, what makes a difference is how quickly things can happen. For example, a history of previous uterine rupture should be on the exclusion list, whereas, for things like HELLP Syndrome, eclampsia, preeclampsia requiring pre-term birth, there are warning signs and while serious, there is time to get the client to the appropriate provider and to the appropriate facility for delivery.
- Staff noted that based on the discussion the recommendation would be for consultation and appropriate monitoring.
- RAC member acknowledged point made by staff in terms of looking at risk factors based on the function of the severity of risk. The analysis of whether a risk requires transfer needs to be a combination of severity of risk multiplied by alacrity of onset; the quickness with which something may happen. If it happens quickly and catastrophically such that there is no time to access appropriate medical care, then that suggests the woman would be safer starting in a medical setting. A severe risk with a very slow onset would not be a reason to exclude because there is time for consultation and transfer. When looking at factors and how a birth center works, a lot of what makes things safer or dangerous in an OOH setting comes down to whether a birthing center can stabilize the risk and transfer if it starts to manifest or does the time necessary to transfer to the hospital increase the risk of death.
- RAC member remarked that with a prior history of eclampsia, onset of preeclampsia, or eclampsia can develop very rapidly, within a matter of hours, and should not be taken off the table without having data on recurrence rates for a history of eclamptic seizure as well as HELLP syndrome.
- RAC member remarked that they appreciate the comment and a person with a history of eclamptic seizure is very serious. On the other hand, while it can happen quickly, with education a birth center could address it.
- RAC member questioned whether the table referred to exclusion for admission including exclusion for prenatal care. Staff remarked that the program is still considering previous discussion regarding allowing a birthing center to continue to provide prenatal care for clients that would be ineligible for an OOH birth.

- RAC member suggested that the title of Table 1 should be changed based on intent. The term "admission" is often thought of in terms of admission at labor not admission to a birthing center. It was suggested that it be retitled "Risk Factors for Exclusion Prenatally."
- Poll Results (keeping maternal history of eclamptic seizure as an exclusion factor at admission for prenatal care):
  - 9% - I can say an enthusiastic yes to the recommendation (or action).
  - 9% - I find the recommendation acceptable and have no serious objections.
  - 9% - I can live with the recommendation, but I'm not overly enthusiastic.
  - 73% - I do not fully agree with the recommendation and need to register concern.
  - 0% - I do not agree with the recommendation and will actively block its movement.
- Poll Results (moving maternal history of eclamptic seizure to consultation at admission for prenatal care):
  - 83% - I can say an enthusiastic yes to the recommendation (or action).
  - 0% - I find the recommendation acceptable and have no serious objections.
  - 17% - I can live with the recommendation, but I'm not overly enthusiastic.
  - 0% - I do not fully agree with the recommendation and need to register concern.
  - 0%- I do not agree with the recommendation and will actively block its movement.

HELLP Syndrome

- November 24th meeting, RAC had requested to change to consultation and to defer discussion.
- RAC member remarked that the recurrence rate of HELLP syndrome is 2-6% with warning signs and recommended it be moved to consultation criteria as there is time to appropriately manage the client.
- RAC member stated that it makes sense that when there is a history of complications or risk of complications that midwives consult with appropriate specialists. It would make sense to consult with someone who has studied a particular risk factor extensively.
- Poll Results: keeping maternal history of HELLP syndrome as an exclusion factor at admission for prenatal care
  - 0% - I can say an enthusiastic yes to the recommendation (or action).
  - 8% - I find the recommendation acceptable and have no serious objections.
  - 8% - I can live with the recommendation, but I'm not overly enthusiastic.
  - 50% - I do not fully agree with the recommendation and need to register concern.
  - 33% - I do not agree with the recommendation and will actively block its movement.
- Poll Results: moving maternal history of HELLP syndrome to consultation at admission for prenatal care
  - 73% - I can say an enthusiastic yes to the recommendation (or action).
  - 27% - I find the recommendation acceptable and have no serious objections.
  - 0% - I can live with the recommendation, but I'm not overly enthusiastic.
  - 0% - I do not fully agree with the recommendation and need to register concern.

- 0% - I do not agree with the recommendation and will actively block its movement.

Pre-eclampsia requiring preterm birth

- Poll Results (keeping maternal history of pre-eclampsia requiring preterm birth as an exclusion factor at admission for prenatal care):
  - 0% - I can say an enthusiastic yes to the recommendation (or action).
  - 0% - I find the recommendation acceptable and have no serious objections.
  - 0% - I can live with the recommendation, but I'm not overly enthusiastic.
  - 17% - I do not fully agree with the recommendation and need to register concern.
  - 83% - I do not agree with the recommendation and will actively block its movement.
- Poll Results (moving maternal history of pre-eclampsia requiring preterm birth to consultation at admission for prenatal care)
  - 42% - I can say an enthusiastic yes to the recommendation (or action).
  - 50% - I find the recommendation acceptable and have no serious objections.
  - 8% - I can live with the recommendation, but I'm not overly enthusiastic.
  - 0% - I do not fully agree with the recommendation and need to register concern.
  - 0% - I do not agree with the recommendation and will actively block its movement.
- RAC member noted that in terms of improvements that can be made, a birthing center will not be able to perform a preterm birth. It should not be mandatory for a consultation when there is maternal history of preeclampsia so that MFM providers are not overburdened with consultations that are not necessary.
- RAC member concurred with no consultation is necessary. Mothers who have had preeclampsia with preterm birth are going to recognize signs and not want to go down the same path. Burdening an MFM with a consult on a mom who is going be to careful, along with the midwife watching for signs and symptoms, is unnecessary.
- RAC member indicated that Oregon really needs to move to a model of integrated maternity care that works so well in other countries. The more that people collaborate, the more of an integrated system that will be developed. It was acknowledged that geography may play a role in support of this model.
- RAC member noted that even if the rules did not require a consult, it does not mean that a woman and/or her provider will not choose to obtain one. Many women may choose to have a co-care model where other women may not choose that model.
- RAC member concurred with comments that it is an undue burden on MFM providers.
- It was noted that this is an exclusion for licensed direct entry midwives but not nurse midwives.
- RAC member remarked that this is an appropriate consult because it is not simply a consult for preterm birth or for preeclampsia. It is a consult for preeclampsia that requires a preterm birth which is a measure of severity and it would be useful to have a full risk evaluation.

- RAC member suggested clarifying a certain gestation period for this risk factor. Staff indicated that if RAC members wanted to suggest such a change to do so.
- Discussion ensued regarding gestation periods and categories of risk.

Fourth-degree laceration without satisfactory functional recovery

- RAC member noted that women meeting this criterion could benefit from midwives. Example shared of a client whose first birth was in a hospital, sustained a 4th degree laceration, developed a fistula, had two surgeries to repair, moved and came to the birth center for care. The client received midwifery care for the pregnancy but then delivered at the hospital. Exclusion from prenatal care is not supported by the draft language.
- RAC member suggested changing to a consultation requirement as "satisfactory functional recovery" is a broad term and depends on when it is measured as it changes over time.
- RAC member stated that it should be a woman's decision with informed consent based on information from providers.
- RAC member noted the criteria is a history of unsatisfactory recovery and these women are under the care of a provider. While there is a risk of recurrence, it is not necessarily an emergency depending on the support and resources in a birthing center.
- RAC member agreed with comments made and would refer a client as necessary. Adding more clarification may make it more effective.
- RAC member remarked that when the pathology or the risk factor listed in the table was caused by unnecessary intervention in previous hospital birth, that is when birthing centers and OOH midwives are confronted with clients who feel strongly about not returning to that model of care. RAC member further stated that it is important to read the studies that show that 4th degree lacerations occur most commonly in the presence of episiotomy and that episiotomy is an ultimate unnecessary routine intervention in a hospital setting. Information was shared from an article and the RAC member noted that the midwifery model of care is getting a baby over an intact perineum and midwives are experts in working with the perineum. Women who select midwifery care have really done their homework in wanting to have a baby with an intact perineum. Follow-up – Study referred to: *Relationship of episiotomy to perineal trauma and morbidity, sexual dysfunction, and pelvic floor relaxation,*" M. Klein et al, American Journal of Obstetrics & Gynecology (1994).
- Staff noted that under HERC guidance 4th degree laceration without satisfactory functional recovery is an absolute exclusion. 3rd degree in prior pregnancy and 4th degree with satisfactory functional recovery is a consult. Staff further noted that it would be helpful to see studies that would support changing to a consultation.
- RAC member noted that this factor is specific to without satisfactory functional recovery and some people may be recommended for a cesarean delivery because of the potential damage to an already nonfunctional pelvic floor. Its best evaluated in a consult to consider the research and individual client risks.

- Poll Results (keeping maternal history of 4th degree laceration w/o satisfactory functional recovery as an exclusion factor at admission for prenatal care):
  - 0% - I can say an enthusiastic yes to the recommendation (or action).
  - 17% - I find the recommendation acceptable and have no serious objections.
  - 0% - I can live with the recommendation, but I'm not overly enthusiastic.
  - 42% - I do not fully agree with the recommendation and need to register concern.
  - 42% - I do not agree with the recommendation and will actively block its movement.
- Poll Results (moving 4th degree laceration w/o satisfactory functional recovery to consultation at admission for prenatal care):
  - 83% - I can say an enthusiastic yes to the recommendation (or action).
  - 8% - I find the recommendation acceptable and have no serious objections.
  - 0% - I can live with the recommendation, but I'm not overly enthusiastic.
  - 8% - I do not fully agree with the recommendation and need to register concern.
  - 0% - I do not agree with the recommendation and will actively block its movement.

Uterine rupture

- Poll Results: (Keeping maternal history of uterine rupture as an exclusion factor at admission for prenatal care):
  - 73% - I can say an enthusiastic yes to the recommendation (or action).
  - 18% - I find the recommendation acceptable and have no serious objections.
  - 9% - I can live with the recommendation, but I'm not overly enthusiastic.
  - 0% - I do not fully agree with the recommendation and need to register concern.
  - 0%- I do not agree with the recommendation and will actively block its movement.
- It was noted by RAC member that women should be able to consult and receive prenatal care if this risk factor is present but should not be able to deliver OOH. The issue of providing prenatal care but delivering in hospital will be considered further.
- RAC member asked if the Oregon Health Authority has jurisdiction over prenatal care. Staff noted that if prenatal care is offered in a clinic separate from the birthing center, OHA does not have jurisdiction. If the prenatal care is provided in the birthing center, then the facility license means OHA has some jurisdiction.

Retained placenta requiring surgical removal

Deferred to next meeting given lack of time.

Next Steps

Staff noted that the next meeting is scheduled for March 2nd. The program will continue to use the polling system and work through the remainder of the tables. RAC members were encouraged to come prepared with relevant data, literature, guidance, etc. to the next meeting.

Meeting adjourned at Noon.

Memorandum

To: Mellony Bernal, Oregon Health Authority
From: Hermine Hayes-Klein, JD on behalf of Oregon Association of Birth Centers
Re: January 24, 2020 RAC Meeting for Birth Center Rules: Corrections to Minutes from November 22, 2019 RAC Meeting
Date: January 27, 2020

At the beginning of the January 24, 2020 OHA RAC Meeting for Oregon Birth Center Rules, I offered the following clarifications regarding the November 22, 2019 meeting minutes. Despite these clarifications, the minutes have been consistently thorough and excellent, and that they had generally captured robust exchanges with accuracy.

1. P.2: "Since implementing the HERC criteria for Medicaid patients, RAC member suggested there was a 75% drop in OOH births for clients covered by OHP."
    a. Clarification: The context of this paragraph suggests that the 75% drop in OHP clients able to access OOH birth is due to OHA's refusal to cover women with risk factors included in HERC. The point that I heard being made at that meeting (by some of the OOH providers, I believe) was that the dramatic decline in access to OOH midwifery services, since implementation of HERC, is due as much to discrimination and bias in OHA's OOH prior authorization process, as to the way OHA is using HERC to deny coverage for OOH births that are within the birth center and the providers' legal scope of practice. See, e.g., the Report from the Out of Hospital Birth Prior Authorization Review Workshop, 9/2018.

2. P.3: "RAC member suggested that the Netherlands have always had a system where healthy women give birth at home with midwives, and that a hospital is backup and they have always had better outcomes than the U.S. Further, what makes an OOH birth safe in another country is integration."
    a. Clarification: I made this point in response to Cat Livingston's remark that many of the risk factors in the HERC Guidelines were included in the guidelines for transfer in nations with the best outcomes for OOH birth, and she cited the Netherlands and the UK. At that point, I didn't suggest, but accurately stated that the Netherlands' healthcare system has always considered childbirth to be a normal physiological event with the potential to become a medical event, rather than a medical event by definition, and have treated it as appropriate for women to give birth at home with midwives, and to save doctors and hospitals for the event that medical treatment is actually needed. I stated that Dutch perinatal and maternal outcomes over the last century have been better than ours, and disprove the American cultural belief that the safest place for normal birth is at the hospital under the care of physicians. Studies out of the Netherlands, the UK and Canada indicate that, when OOH birth is integrated, it has the same short-term perinatal outcomes as planned hospital birth, but much healthier long-term outcomes for mother and baby. The thing that makes OOH birth safe in nations like the Netherlands, UK and Canada is integration and continuity of care, not guidelines imposed as rules restricting access to midwifery care. The authors of the Oregon

Snowden study expressed this point publicly, stating that the conclusions from their study should not be to blame midwives or to restrict access to OOH birth, but to improve integration and continuity of care.

b. My main point was that it is important to understand that all of the nations with safe OOH maternity services treat their guidelines for transfer from midwifery to medical care as intersectional with the woman's right of informed choice, and the provider's bioethical duty of non-abandonment. Women are provided with midwifery care if they refuse medical care, and ensured secure access to medical services in the event they come to need or choose them. Secure integration and access to care should be the focus of OHA's effort to optimize safety for OOH birth.

3. P.4: "D. Selover remarked that the OHA and the RAC are not arguing about the rights of individuals, but rather having a conversation about how to apply the statutory definition of a freestanding birthing center licensed primarily for the purpose of performing low risk deliveries."
    a. Clarification: My response to Dana's point here didn't make it into the minutes, but I think it's important:
        i. This committee is meeting to write the regulations that will affect which women can or cannot give birth at a birth center, given the medical risk factor Tables that Oregon uses to define access to birth center care. Under Oregon birth center rules, licensed birth centers cannot provide services to women with the risk factors listed on the Tables. The existing Tables were presumably drafted with the idea that they would keep women and babies "safe." The drafters of these proposed rules presumably have data indicating that there is a safety gap that justifies adding many more risk factors to the Tables, and therefore excluding many more women from birth center care. This committee meeting is the time for OHA to present the evidence indicating that adding the new risk factors on the draft tables would actually serve the goal of "safety."
        i. However, while the purpose of the regulations is obviously to optimize public health and safety for the women who give birth in Oregon and their babies, it should go without saying that these regulations, which are laws, must be written in a way that anticipates, respects, and upholds the legal rights of the people affected by those rules. The Oregon Health Authority, and its agents and representatives, are the State. It is one thing for hospitals to routinely ignore and violate the legal rights of pregnant women, as they do by withholding healthcare support for vaginal birth, and offering only support for surgical delivery, to women with risk factors that they don't like or find inconvenient, like prior cesarean section. But the State of Oregon doesn't have that luxury. The State of Oregon has the obligation to respect and uphold its citizens' rights. That includes their rights to medical decision-making generally, and pregnant women's rights to make medical decisions on behalf of both themselves and their unborn babies, in particular.

ii. This committee has a choice, whether to write regulations that respect and uphold the reproductive, constitutional, and human rights of women in Oregon to make informed medical decisions, even if they make decisions that we personally would not make. Or this committee can erode those rights by drafting regulations that ignore women's rights to make the safest decision for themselves and their babies, and abandon care if they make certain decisions, with the result of diminished safety. Portland, Oregon should be a place where women's rights are not only remembered and recognized as relevant to the laws that affect them, but are protected and secure.

4. P.6: "Everyone is looking out for the baby and everyone is concerned about outcomes. When looking at decision-making, the mother is the most concerned and vested in the outcome of a birth. Women are making choices based on best intentions and knowledge."
    a. My point here didn't make it into the minutes:
        i. Everyone involved in a birth is making decisions on the basis of best intentions and knowledge, patient and providers. And no matter who is making the decision, sometimes babies do not survive childbirth. No matter how everybody involved may feel about the risks of a tragic outcome, no matter how scared anybody may be for the baby, there is no legal question about who has the right to make decisions for the baby, during pregnancy and childbirth. That person is the mother, the pregnant woman, because when she makes decisions for the baby, she is also making decisions about her own body. There is no law, in Oregon or federally, that has removed pregnant women from the class of people who get to make autonomous medical decisions. Therefore, any discussion of the rights and needs of the baby need to make clear for the minutes that legally, the rights of the infant are protected by respecting its mother, and her right to make decisions on both of their behalves. The rights, and needs, of the baby are not protected by bullying and coercing pregnant or birthing women into medical interventions that they don't want, in the names of "the rights of their unborn baby."

5. P.7: "RAC Member noted that the amount of informed choice in a birthing center is profoundly different than what is offered in other health facilities."
    a. By "profoundly different," the RAC member (not myself) was explaining that the informed consent/ choice process is far more thorough, detailed, meaningful, and frequent in birth centers than in other health facilities, because informed consent and patient autonomy are foundational to the midwifery model of care.

Thank You!