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Birthing Center Rule Advisory Committee
March 8, 2022
1:00 p.m. via Zoom

RAC MEMBER ATTENDEES	
Danielle Meyer	Oregon Association of Hospital and Health Systems
Desiree LeFave	Bella Vie Gentle Birth Center (Administrative)
Hermine Hayes-Klein	Oregon Association of Birth Centers
Karen DeWitt	Oregon Association of Naturopathic Physicians
Kaylyn Anderson	Consumer
Laura Erickson	Alma Midwifery Services
Lynette Pettibone	American Association of Birth Centers
Margy Porter	Bella Vie Gentle Birth Center (Clinical)
Michelle Zimmerman-Pike	Oregon Affiliate of the American College of Nurse Midwives
Sarah Wickenhagen	Oregon State Board of Nursing
Silke Ackerson	Oregon Midwifery Council
Stefanie Rogers	Providence Hospital
Willa Woodard Ervin	Rogue Birth Center
OTHER INTERESTED PARTY ATTENDEES	
Christina Clay	Care Oregon/Alma Midwifery
Kori Pienovi	Women's Healthcare Associates' Midwifery Birth Center
Melissa Kaiser	Women's Healthcare Associates' Midwifery Birth Center
Molly Okerman	Women's Healthcare Associates' Midwifery Birth Center
Ray Gambrill	AllCare Health
Sharron Fuchs	Public
Stephanie Bates	Public
OHA Staff	
Anna Davis	PHD-Health Facility Licensing & Certification
Dana Selover	PHD-Health Care Regulation & Quality Improvement
Diane Quiring	Health Systems Division – Medicaid Programs Unit
Jason Gingerich	Health Evidence Review Commission
Lacey Martinez	PHD-Health Facility Licensing and Certification
Mellony Bernal	PHD-Health Care Regulation & Quality Improvement
Rebecca Long	PHD-Emergency Medical Services & Trauma Systems Program
Samie Patnode	PHD-Health Licensing Office

Welcome and Overview

Mellony Bernal welcomed Birthing Center Rule Advisory Committee (RAC) members and other interested parties and reviewed housekeeping items. Participants were asked to enter their name, organization and whether they are a RAC member, member of public, or staff of Oregon Health Authority into the Chat.

February 15, 2022 Meeting Notes

RAC members were asked via e-mail to submit any comments on proposed changes to the February meeting notes to Mellony Bernal by e-mail. **Follow-up: Corrections have been made to list of attendees for the February 15th meeting.**

Overview of Agenda

D. Selover reviewed agenda. The goal is to get through the remainder of Table II, review some changes to administrative rule text based on previous RAC discussions, and discuss structure of next RAC meeting.

Risk Factor Table II – Risk Factor Criteria for Transfer to Hospital during Intrapartum or Postpartum Care

D. Selover reminded RAC members that Table II was revised removing references to "consideration." Therefore, for voting purposes, Table II consists of risk factors that would require transfer to a hospital.

Postpartum/Newborn
Congenital anomalies (unexpected, significant or life-threatening)

RAC member remarked that while this is a situation where the intent and prognosis is for the baby to live and need special care after birth, there are many kinds of congenital anomalies, including anomalies that are incompatible with life and which are known. It would be appropriate for a client to choose a birth center birth knowing the outcome.

Further discussion:

- RAC member concurred with comment above and asked that the wording be changed to consider scenario.
- RAC member indicated via Chat that the term "significant" is open to interpretation. "Life-threatening is meaningful but should also include known anomalies incompatible with extrauterine life."
- D. Selover inquired about the Board of DEM, Licensed Direct Entry Midwives (LDM) rules. Health Licensing Office (HLO) staff remarked and noted via Chat the LDM rules specify that "evident or suspected major congenital anomaly" is an indication for consult. D. Selover further noted that HERC requires a consult.
- Staff noted that if unexpected is modifying both significant and life-threatening than an "expected life-threatening anomaly" would not fall under this category.

- RAC member stated that if a family wanted non-intervention for an infant with, for example Trisomy 13, it would be appropriate to allow a consultation and gives the family an option to make an informed decision. An infant with a congenital heart lesion for example, should be delivered at an inpatient facility. Consult would be appropriate as each congenital anomaly is different and a plan should be developed for the family.
- RAC member remarked that criterion should be reworded or moved to consultation.
- The following comments were provided via Chat by RAC members:
  - Change risk factor to a consultation requirement
  - Language is confusing. The factors could be clearer, and consult would be a better option for families and providers
  - Move to consult to protect families' choices
  - Clearer language is needed
  - Change to "Congenital anomalies life-threatening (unless known anomaly not compatible with life)

<u>POLL: Retain "Congenital anomalies (unexpected, significant or life-threatening)" as a mandatory transfer criterion. Results:</u>

- 0% - I can say an enthusiastic yes to the recommendation (or action).
- 9% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 18% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 64% - 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.
- 9% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

<u>Excessive bruising, enlarging cephalohematoma, significant birth trauma</u>

RAC member suggested that these criteria are very different and should be separated. It was stated that enlarging cephalohematoma or significant birth trauma would be transported; however, excessive bruising may result in a consult, treatment or watched. It was suggested that excessive bruising be removed.

Further discussion:

- RAC member also suggested removing excessive bruising stating it's a risk factor for jaundice which most midwives are aware of and follow recommendations. RAC member supported transfer requirement for both enlarging cephalohematoma and significant birth trauma.
- RAC members via Chat shared the following:
  - Should be a consult
  - Agree with moving 'excessive bruising' to consult
  - Significant birth trauma is too vague for transfer criteria; don't know what it means; depending on the actual intent could support
  - Agree with above statement; needs further clarification

- [Significant birth trauma] Needs improvement because it's too vague
- Several additional RAC members concurred that significant birth trauma is too vague.

POLL: Retain "Excessive bruising" as a mandatory transfer criterion. Results:

- 0% - I can say an enthusiastic yes to the recommendation (or action).
- 8% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 8% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 17% - 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.
- 67% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

POLL: Retain "Enlarging cephalohematoma" as a mandatory transfer criterion. Results:

- 50% - I can say an enthusiastic yes to the recommendation (or action).
- 25% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 17% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 8% - 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.
- 0% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

POLL: Retain "Significant birth trauma" as a mandatory transfer criterion. Results:

- 25% - I can say an enthusiastic yes to the recommendation (or action).
- 50% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 0% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 25% - 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.
- 0% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

Hyperglycemia or hypoglycemia unresponsive to treatment

D. Selover noted that 'unresponsive to treatment' refers to both hyper- and hypoglycemia.

RAC member agreed with keeping hypoglycemia unresponsive to treatment as a transfer criterion. It was noted that clients with significant glucose issues are not seen so hyperglycemia is something that is not seen a lot.

Further discussion:

- Hyp**er**glycemia may be seen in extremely low birth weight infants or sometimes early with sepsis (glucoses of 200 or 300) which need a more thorough evaluation. It is very rare but if real can signify bad things.
- RAC member indicated support of keeping both criteria.
- RAC member via Chat indicated "I don't know what the "birth center Rx" would be for hyper- we treat hypo- KEEP"

<u>POLL: Retain "Hyp**er**glycemia unresponsive to treatment" as a mandatory transfer criterion.</u>
<u>Results:</u>
- 75% - I can say an enthusiastic yes to the recommendation (or action).
- 25% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 0% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 0% - 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.
- 0% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

RAC member stated concerns with wording, 'Hyperglycemia unresponsive to treatment.' If a birth center has a hyperglycemic infant, it is not within scope to treat in a birth center. It was questioned whether the wording gives allowance for trying to bring a baby's blood sugar down in a birth center setting; stating just "hyperglycemia" should be adequate.

Further discussion:
- RAC member responded that it would be an exceedingly rare occurrence and it would be reasonable for a provider to recheck a glucose with an infant that appears to be well and not transport right away. The RAC member concurred that there is not a lot in terms of treatment that a birth center can do, but the wording and intent is appropriate.
- RAC member via Chat indicated an individual can always act more conservatively.
- D. Selover noted that the language does not say you must treat before transfer. Different actions may be taken based on whether there are multiple factors going on and clinical judgement does play a role.
- RAC member noted that she is hoping that the language does not give the impression that a birth center can delay transfer for an infant who is hyperglycemic and waste valuable time getting the infant treated.
- RAC member via Chat indicated a change in vote from a 5 to a 1.

<u>POLL: Retain "Hyp**o**glycemia unresponsive to treatment" as a mandatory transfer criterion.</u>
<u>Results:</u>
- 75% - I can say an enthusiastic yes to the recommendation (or action).
- 25% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 0% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.

- 0% - 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.
- 0% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

Hypotonia, tremors, seizures, hyperirritability

HLO staff noted that LDM rules indicate that seizures and significant hypotonia is an indication to transfer. Hyperirritability and tremors are not listed in the LDM rules for consult or transfer.

RAC member suggested via Chat that 'tremors' and 'hyperirritability' are too subjective and recommended removing. Hypotonia and seizures should be kept as mandatory transfer.

Further discussion:

- RAC member shard examples and commented that the 'immature system of the baby sometimes will do that [seizures]' and suggested that consult be considered when [seizures] are considered benign. RAC member responded that true seizures (versus tremors) likely indicate a significant need for evaluation (such as neonatal stroke) that needs intervention whereas tremors or irritability would not be an indication for any sort of mandatory consult or transfer because those can be normal in newborns. She further indicated support of mandatory transfer for hypotonia and seizures and agreed with the Board of DEM criteria that tremors and hyperirritability are very vague and should be removed.
- Another example was shared and RAC member responded that generalized seizures are more concerning for a hypoxic injury and focal seizures would be more concerning for some intracranial pathology and may not be benign. True seizures need to be confirmed with EEG criteria to confirm an electrographic correlate.
- RAC commented and shared via Chat recommendation to reword as mandatory transfer for seizures and significant hypotonia and remove tremors and irritability. Several RAC members via Chat agreed with recommendation.
- RAC member concurred with comments about keeping seizures and hypotonia and removing tremors and irritability but questioned hypotonia for example in an infant with down syndrome who might have hypotonia or hypotonia right after birth that resolves within 10-15 minutes. RAC member responded that she interpreted the text to mean unexplained hypotonia, not an infant who has hypotonia related to an infant, for example, who is given glucose gel and hypotonia resolves.
- RAC members suggested via Chat changing to 'persistent hypotonia' or 'persistent, unexplained hypotonia.'

POLL: Retain "Hypotonia" as a mandatory transfer criterion. Results:

- 8% - I can say an enthusiastic yes to the recommendation (or action).
- 33% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.

- 17% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 33% - 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.
- 8% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

POLL: Retain "Tremors" as a mandatory transfer criterion. Results:
- 17% - I can say an enthusiastic yes to the recommendation (or action).
- 8% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 8% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 25% - 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.
- 42% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

POLL: Retain "Seizures" as a mandatory transfer criterion. Results:
- 75% - I can say an enthusiastic yes to the recommendation (or action).
- 17% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 0% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 8% - 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.
- 0% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

POLL: Retain "Hyperirritability" as a mandatory transfer criterion. Results:
- 8% - I can say an enthusiastic yes to the recommendation (or action).
- 0% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 25% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 33% - 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.
- 33% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

Low Apgar score - <5 at 5 minutes; <7 at 10 minutes

HLO Staff via Chat noted that LDM rules specify an Apgar less than seven at 10 minutes of age is a transfer.

RAC member indicated that most birth centers have in their policies and procedures a low Apgar of 4 or less at 5 minutes, 9-1-1 is always called, but there are times that once EMS is on scene the baby is improving and is not transferred. She further indicated that less than 7 at 10 minutes should be a transfer.

Further discussion:

- RAC member via Chat concurred with comment above.
- RAC member noted that Apgar's are subjective and not firmly associated with outcomes; however, the recommendations are reasonable, and comfortable keeping both. Less than 5 at 5 minutes is most important.
- Several RAC members via Chat concurred with comment above.

<u>POLL: Retain "Low Apgar score <5 at 5 minutes" as a mandatory transfer criterion. Results:</u>

- 25% - I can say an enthusiastic yes to the recommendation (or action).
- 50% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 17% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 8% - 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.
- 0% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

<u>POLL: Retain "Low Apgar score <7 at 10 minutes" as a mandatory transfer criterion. Results:</u>

- 25% - I can say an enthusiastic yes to the recommendation (or action).
- 42% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 17% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 17% - 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.
- 0% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

RAC member inquired if at the time EMS arrives and the baby is stable and appears to be well, would this mean that the birth center would not need to transfer? D. Selover responded that it depends, and providers can work within their clinical practice. Providers should be watching more than just the Apgar and should be able to work with this. A complaint investigation is going to look at more than just the result of an Apgar score. RAC member suggested that additional language should be considered that clarifies that a clinician can decide not to transfer if infant is improving.

RAC member via Chat indicated:

- [Table II] were forcing functions, otherwise [risk criterion] would be recommendations.

- Adding 'not improving' makes all the difference on Apgar's. Parents won't want to send a well-baby to hospital, even if they had a low Apgar and now, they are pink and crying.
- RAC member concurred with comment above.

Respiratory or cardiac irregularities, cyanosis, pallor

HLO staff noted that the LDM rules specify the following:

- Indication for consult – Newborn includes persistent cardiac murmur, respiration rate greater than 100 within the first two hours postpartum, and greater than 80 thereafter, lasting more than one hour without improvement.
- Indication for transfer – Newborn includes central cyanosis and unresolved pallor at birth.

RAC member noted that a baby with central cyanosis is transferred. It is unclear what a baby with cardiac irregularity means (a baby with a murmur?) and should be reworded.

Further discussion:

- RAC member remarked that there is a wide variety of what that could be [cardiac irregularity] and how it would be interpreted. TPN given as an example or murmur. RAC member further indicated that some of these irregularities may be addressed through a pediatric consult.
- RAC member concurred via Chat with comment above.
- HLO Staff noted that the Board of DEM did consider certain types of health care provider requirements for consultations, however for the risk factors noted there were no specific provider requirements.
- RAC member supported the vagueness in the criterion 'respiratory or cardiac irregularities' rather than murmur. A murmur should be evaluated by a pediatrician via consult and shouldn't need to be transferred to the hospital. The respiratory rate in the LDM rules is supported and adds good clarity and is reasonable. Cyanosis should be revised to indicate 'central cyanosis.' Pallor does not add a lot and is very subjective. Maintaining cardiac irregularities is appropriate (example provided of recent transfer from midwife for evaluation of premature atrial contractions and abnormal heart rate). This would not preclude a home delivery.
- RAC member remarked and via Chat suggested that it would be helpful to add something about the Critical Congenital Heart Disease (CCHD) screen. Would failing the CCHD screen be a better indicator for the newborn who needs transfer to a hospital?
- RAC members via Chat indicated the following:
  - Adding “unresolved” would help with clarification
  - Agree that 'respiratory and cardiac irregularities' is too vague
  - Agree that 'unresolved' would help clarify
  - Agree that 'irregularities' is too vague
  - Add "central" to cyanosis vs acrocyanosis
  - Support Board of DEM language and amending to central cyanosis
  - CCHD is a consult versus transport as it is done after 24 hours
  - Agree with LDM rules
  - Change cardiac to "significant cardiac irregularities"
  - Add "or signs of respiratory distress unresponsive to treatment"

Staff noted that for purposes of polling, RAC members vote on the following:

POLL: Retain "Respiratory or cardiac irregularities" as a mandatory transfer criterion. Results:

- 8% - I can say an enthusiastic yes to the recommendation (or action).
- 33% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 0% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 42% - 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.
- 17% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

Staff noted that for purposes of polling, RAC members vote on the following:

POLL: Retain "Central cyanosis" as a mandatory transfer criterion. Results:

- 50% - I can say an enthusiastic yes to the recommendation (or action).
- 25% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 0% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 25% - 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.
- 0% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

POLL: Retain "Pallor" as a mandatory transfer criterion. Results:

- 0% - I can say an enthusiastic yes to the recommendation (or action).
- 10% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 20% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 30% - 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.
- 40% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

Temperature instability, fever, suspected infection or dehydration

HLO staff noted via Chat the LDM rules state, 'persistent inability to maintain temperature between 97 to 100 degrees Fahrenheit or 36 to 37 degrees Celsius' and 'Evident or suspected infection' are indications to transfer for newborns. Dehydration is not specifically listed.

- Several RAC members via Chat agreed with the DEM wording indicating it makes it much clearer.
- RAC member commented and indicated in Chat that 'dehydration' doesn't belong with the other factors and recommended separating the risk factors. Additionally, she indicated support of removing dehydration.
- RAC member agreed with comment above and asked for clarification around time frame for temperature instability. The language is too vague.
- RAC member via Chat indicated 'leave fever and infection – the other two do not belong here.
- RAC member via Chat stated, "What is to keep suspected infection to include thrush? Too vague."

Staff noted that for purposes of polling, RAC members vote on the following:

<u>POLL: Retain "Temperature instability or fever" retain as mandatory transfer criteria. Results:</u>

- 8% - I can say an enthusiastic yes to the recommendation (or action).
- 33% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 25% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 17% - 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.
- 17% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

<u>POLL: Retain "Suspected infection" as mandatory transfer criterion. Results:</u>

- 75% - I can say an enthusiastic yes to the recommendation (or action).
- 17% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 0% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 8% - 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.
- 0% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed

<u>POLL: Retain "Dehydration" retain as a mandatory transfer criterion. Results:</u>

- 0% - I can say an enthusiastic yes to the recommendation (or action).
- 9% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 27% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 27% - 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.

- 36% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

Vomiting/Diarrhea

HLO staff noted via Chat that the LDM rules indicate "persistent projectile or bilious vomiting or emesis of fresh blood" is an indication to transfer. Diarrhea is not specifically listed.

RAC member commented that it is common for an infant several hours after birth to "choke up something" and questioned whether that would be considered vomiting. Support for the Board of DEM language was indicated.

Further discussion:

- Via Chat, RAC member noted that it is common for babies to vomit birth fluid and mucus.
- RAC member commented that the DEM criteria could be supported and vomiting, or diarrhea do not indicate a need for transfer.
- RAC members via Chat stated:
  - Vomiting and diarrhea are too vague. LDM rules would be ok to include.
  - Agree with projectile and bilious vomiting is being an indicator.
  - "We are LDMs (Licensed Direct-Entry Midwives not DEM's. When we discuss these rules, they are LDM rules, made by the Board of Direct-Entry Midwifery." **FOLLOW-UP – These meeting notes have been updated replacing 'Board of DEM rules' with LDM rules.**

POLL: Retain "Vomiting and diarrhea" as a mandatory transfer criterion. Results:

- 0% - I can say an enthusiastic yes to the recommendation (or action).
- 0% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 9% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 18% - 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.
- 73% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

Weight less than 5th percentile for gestational age

HLO staff noted via Chat that the LDM rules indicate "weight less than 2,270 grams (five pounds)" is an indication to transfer.

RAC member commented that this factor should likely be removed. For a weight less than the 5th percentile, the provider should ensure that the infant stays normal glycemic and normal thermic and if they can do those things, it doesn't matter if their weight is less than the 5th percentile.

POLL: Retain "Weight less than 5th percentile for gestational age" as a mandatory transfer criterion. Results:

- 0% - I can say an enthusiastic yes to the recommendation (or action).
- 8% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 33% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 33% - 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.
- 25% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

D. Selover thanked RAC members for their comments and feedback. The OHA will take these comments into consideration. Members of the RAC and other interested parties will have an opportunity to comment on final proposed changes to the tables during the public hearing. D. Selover also thanked Samie Patnode for providing information on the LDM rules during this meeting.

OAR 333-077 Rule Text

M. Bernal provided an overview of the revised rule text which has been amended based on previous RAC discussions and input from RAC members.

- The different colors of rule text should be ignored.
- Underlined text means new language.
- Stricken text will be deleted.
- Text highlighted in yellow indicates changes from the initial version shared on May 30, 2019.

D. Selover noted that while there is a lot of highlighted yellow text, the OHA is asking for input on specific sections as noted below. Additional comments or feedback can be sent to Mellony Bernal via email at mellony.c.bernal@dhsoha.state.or.us.

OAR 333-077-0010 (6) and (7) – Definitions
OAR 333-077-0070 – Governing Body
OAR 333-077-0080 – Personnel

The terms clinical provider and clinical staff have been added and definitions proposed based on the Commission for the Accreditation of Birth Centers (CABC), Indicators of Compliance with Standards for Birth Centers. Conforming amendments using the terms have been made including in the rule related to Governing Body and Personnel.

- Clinical provider means a physician, certified nurse midwife or licensed direct entry midwife who are ultimately responsible for the clinical care of a client.
- Clinical staff means any individual among all staff who perform tasks or have responsibilities in clinical care.

Discussion:

- RAC member stated via Chat that Naturopathic Doctor/Midwife would need to be added to the provider list unless it is included under the definition of physician. D. Selover responded that they have been included under the physician definition.
- RAC member indicated via Chat that definition of clinical provider would work for purposes of CNMs.
- No additional comments were provided by RAC members.

333-077-0100(8) – Client care services

Language has been added allowing a clinical provider to use telemedicine for prenatal and postpartum care after an initial, in-person assessment is completed and no risk factors or complications were identified. The rule further defines telemedicine and requires a set number of in-person assessments and proposes that telemedicine may not occur after 39 weeks, 6 days.

- A clinical provider may use telemedicine to provide prenatal and postpartum care to clients after completion of an initial, in-person assessment and no risk factors or complications were identified.
  (a) Telemedicine may be conducted through electronic and telecommunication technologies such as video communication, teleconference, landline or wireless communications. Synchronous communication between the clinical provider and the client is required.
  (b) A clinical provider must ensure that an in-person assessment is completed with the client at least two times between 28 to 36 weeks, and two times between 36 weeks to 39 weeks, 6 days.
  (c) Telemedicine may not be conducted after 39 weeks, 6 days.

Discussion:

- D. Selover reminded RAC members that Birth Center rules focus on patient health and safety while other agencies have rules specific for payment, insurance, etc. D. Selover asked whether Medicaid rules were reviewed to ensure there is no conflict. Staff indicated no and will follow-up.
- RAC member indicated that time periods for in-person assessment is unclear as 36 weeks is used in two places. It was also asked what the rationale was for not allowing telemedicine after 39 weeks, 6 days. Patients are being seen in person after this time period; however, if someone develops UTI symptoms after 39 weeks, 6 days a telehealth visit should be acceptable when a person can be sent to the lab and get treatment.
- RAC member noted that further clarification is needed where it states 'no risk factors or complications' have been identified. For example, a client with iron deficiency anemia can be considered a risk factor but doesn't necessarily mean that all visits need to be in-person. Consideration also needs to be given to persons who may test positive for COVID and as such needs to quarantine and couldn't have an in-person visit.
- RAC member via Chat concurred with above comment and noted that many pregnant women have been unable to come to clinic for suspected or confirmed COVID-19.
- RAC member commented that telehealth is one way to determine whether a client is a good fit for the agency and vice versa. It was questioned whether the first visit would

need to be an in-person assessment when some first visits are a way to determine whether the client and birth center can work together. Staff noted that proposed rule language under OAR 333-077-0125 requires that an initial risk assessment be performed in-person within 21 calendar days of the initial prenatal care visit. RAC member via Chat asked that "in-person risk assessment visit" be considered for wording.

- D. Selover thanked RAC members for comments and encouraged members to submit suggested revisions to M. Bernal. She further indicated that consideration will be given to making the language more generic.
- **Follow-up – The suggested time periods for in-person visits was based on the American Academy of Pediatrics/American College of Obstetrics and Gynecologists, Guidelines for Perinatal Care, Eighth Edition – Frequency of Visits.**

333-077-0160 – Dietary Services

M. Bernal noted that the Dietary Services rule has been re-rewritten and proposed language is based on discussions with the Public Health Division's, Environmental Health Foodborne Illness Prevention Program. Consideration has been given based on previous remarks from RAC members to allow ordering from food delivery services and restaurants. Compliance with rigorous food sanitation rules, OAR chapter 333, division 150 was removed.

- RAC member asked that additional time be allowed to consider the dietary rule and bring forward additional comments at a future meeting. Some birth centers are located where food delivery is not an option and client dietary needs must be considered.
- RAC member stated that the proposed rule creates unrealistic restrictions in the birth center kitchens. When a facility is licensed, the kitchens are walked through as well. Concerns were noted about "individually packaged, single-serving foods" and "single service utensils."
- RAC member stated via Chat that single use utensils shouldn't be necessary or appropriate.

D. Selover asked that RAC members provide M. Bernal with suggested edits. She also asked whether there were additional rules that RAC members wanted to discuss.

- RAC member asked whether there is a requirement for a food handlers license in the proposed rule and staff responded no.

Planning for Future Meetings

D. Selover noted that the next meeting will be to discuss gestational age, multiple births, non-cephalic presentation and VBAC risk factors.

- RAC members were reminded that per statute, birthing centers are for low-risk births. The Health Evidence Review Commission also uses low risk births for purposes of the Coverage Guidance for Planned Out-of-Hospital Birth.
- The OHA regulates the facility, and the expectation is that policies and procedures are in place and rules are followed.
- Regulating the practitioner (MD, CNM, LDM, ND, etc.) is different than regulating the facility and investigations are substantially different between the two.

- It's important to remember this different when approaching the risk factors, especially since there are multiple providers working in a birth center.
- D. Selover suggested one to two more meetings and suggested grouping gestational age, multiple births and non-cephalic presentation in one meeting, and VBACs in a separate meeting. It was noted that the Public Health Division does not have the same set up to look at the evidence in a rigorous way such as HERC or the Board of DEM.
- It was noted that more members will be considered including subject matter experts.
- RAC member commented via Chat that the CABC has reviewed the evidence with respect specifically to Birth Centers.
- The goal is to submit these rules for Public Hearing before the end of the year, preferably by the end of summer.
- Staff from HERC noted that they continue to monitor literature and if anything is seen that might indicate a change to the guidance would be reviewed further. Generally, guidance is reviewed every five years. Persons that wish to share literature with the HERC may do so by contacting them at HERC.Info@dhsoha.state.or.us.
- In response to RAC member who asked whether dates have been identified for future meetings including VBAC, dates have not been identified.
- RAC member asked whether HERC could have a subject matter expert available to respond to the birthing centers' subject matter expert to discuss the biggest concerns relating to VBAC. HERC staff noted that their report is posted and available for review including references to the evidence reviewed. Meeting minutes are also posted and available for review. It was noted that the February 2020 meeting minutes from the Evidenced-based Guidelines Subcommittee states: *Under delivery history, the subcommittee discussed comments which recommended allowing coverage for out-of-hospital births for women with prior successful vaginal deliveries as well as prior cesarean sections. After discussion, the subcommittee affirmed its decision to leave this as a transfer criterion based on professional guidelines and several studies associating prior cesarean with poor outcomes in the out-of-hospital setting. In addition, many Oregon hospitals lack the infrastructure and staffing to handle any emergency transfers which may occur.* HERC attendance at future meetings will be based on staff availability. RAC member stated that historically Oregon has had excellent statistics in regard to VBAC.
- D. Selover noted that Table III relating to consultation will be edited after further consideration of RAC input from Tables I and II.
- D. Selover further noted that with regard to HB 2993, there is no clear solution on how to obtain community input in the middle of a RAC process. The program is continuing to work on how to design this.

RAC adjourned at: 3:00 p.m.