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Birthing Center RAC
July 17, 2019
9:00 – Noon; Room 1E

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	Chair, Board of Direct Entry Midwives
Jennifer Gallardo	Andaluz Birthcenter
Jason Gingerich (phone) for Cat Livingston	OHA-Health Evidence Review Commission
Hermine Hayes-Klein	Oregon Association of Birth Centers
Ruby Jason	Oregon State Board of Nursing
Desiree LeFave	Bella Vie Birth Center
Rebecca Long	OHA-EMS and Trauma Systems
Meredith Mance	Aurora Birth Center
Samie Patnode	OHA-Health Licensing Office
Margaret Porter (phone)	Bella Vie Birth Center
Stefanie Rogers	Providence Health System/Legacy
Anna Stiefvater	OHA-Public Health, Maternal & Child Health
Alice Taylor	American Association of Birth Centers
Willa Woodard-Ervin (phone)	Rogue Birth Center
Michele Zimmerman-Pike (phone)	American College of Nurse Midwives
OTHER INTERESTED PARTY ATTENDEES	
Brooke Bina (phone)	Alma Midwifery Services
Olivia Bunn	Consumer
Hannah Cornman	Consumer
Debbie Cowart	Growing Family Birth Center
Doreen Davis	OHA-Health Licensing Office
Sharron Fuchs	Chiropractor trained in out-of-hospital births
Lindsie Lincoln	Growing Family Birth Center
Lynette Pettibone	Consumer
OHA PHD Staff	
Anna Davis	Survey and Certification Manager, Health Facility Licensing and Certification
Lacey Martinez	Surveyor, Health Facility Licensing and Certification
Dana Selover	Section Manager, Health Care Regulation & Quality Improvement

Mellony Bernal	Administrative Rules and Legislative Policy Analyst, Health Care Regulation & Quality Improvement

Welcome / Overview

Dana Selover welcomed RAC members and RAC members introduced themselves. Members of the public also introduced themselves.

D. Selover provided a brief overview of the agenda and restated the goal is to have rules filed by October/November for purposes of a public hearing and have rules in effect by January 2020.

Meeting notes have been drafted that summarize the May meeting. Audio files of the meetings are available upon request. It was noted that the action items from the May meeting are still in progress and will be shared at a future meeting.

Comments on notes:

- Correction made to Sharron Fuchs title.

RAC members that were unable to attend the May meeting provided the following comments with respect to possible changes to the rules. The following comments do not reflect the May meeting discussion:

- Efforts should be made to make sure that definitions are non-discriminatory, such as consistency in how definitions for health professionals are framed.
- Consider looking to the American Association of Birth Centers (AABC) for the definition of 'freestanding birthing center' which avoids low risk/high risk language. References to uncomplicated should be removed throughout the rules and replaced with normal physiological birth. Risk is a spectrum and many risks can be managed in a birth center as a midwife is able to stabilize some complications. A birth center therefore can facilitate a birth that may have complications, but complications were resolved.
    - Staff noted that statutory requirements, including any definitions that are established in statute, must be considered. (Freestanding birth center is defined in statute (ORS 442.015) and includes reference to low risk deliveries.) Clarifying language can be considered and the program can also provide interpretive guidance for purposes of administrative rules.
- It was also suggested that the rules need to ensure that the administration of surveys and investigations guards against cultural bias of out-of-hospital (OOH) births. It was suggested that many investigations against birth centers and midwives is a result of cultural bias. Additional clarification is needed to describe who will be conducting the initial assessment to determine whether a complaint is investigated and, if an investigation is warranted, who will be conducting the investigation. It was suggested that persons conducting the investigation be of the same license type of the people under investigation and have personal experience with OOH births.
- RAC member representing the Oregon State Board of Nursing noted there appears to be a significant misunderstanding on how CNAs can or cannot be used based on the discussion noted in the minutes regarding supervision of CNAs. RAC member clarified that a CNA can only be supervised by and take direction from a licensee of the Oregon State Board of Nursing, i.e. LPN, RN, or CNM. CNAs cannot be supervised by or take direction from a physician, naturopath or licensed

direct entry midwife. It was further noted that if a CNA does not work under the direct supervision of a licensee of the Board of Nursing, they would be working as an unregulated care provider and any hours worked could not be counted toward license renewal. CNAs do not have a scope of practice, rather authorized duties under OAR chapter 851, division 63.

- RAC member noted that the AABC does have a certified birth assistant (CBA) training for unlicensed providers and according to the Commission on Accreditation of Birth Centers (CABC) accreditation standards, there is a system in place that does allow a CBA to stay and provide care postpartum if a client is ready for discharge rather than a midwife.

ACTION: 1) Consider changes to definitions for provider types using consistent terms; 2) consider providing clarification for the definition of 'freestanding birth center' to address use of terms relating to risk; 3) provide the RAC with additional information about OHA process for complaint investigations and surveys; and 4) ensure that rule language is written that avoids any conflict with the nurse practice act with respect to CNAs.

Proposed Rule Changes

D. Selover reminded RAC members that proposed rules were drafted based on the following:

- Alignment with other facility type licensing rules;
- Consideration of other Oregon agency and board rules including the Health Evidence Review Commission and Board of Direct Entry Midwifery;
- Consideration of other states' regulations and national accrediting boards; and
- Federal or nationally recognized guidance.

OAR 333-077-0090 – Policies and Procedures

D. Selover noted that policies and procedures mostly contain things that may also be detailed in other rules. For example, the requirement for an infection control policy, points to a rule specific to infection control which will identify specific requirements.

The following comments were provided on specific sections:

- Section (2) requires that the care and services of a client in a birthing center must be supervised by specified providers.
  - Reference to certified nurse midwife needs to be changed to licensed nurse midwife given passage of recent legislation. This section also references nurse practitioners (NP) and it was noted that NPs by their training and competency do not have the legal scope of practice to deliver babies. Licensed nurse midwives are also NPs, so it was recommended that reference to NPs be removed.
  - Question was raised about the term 'certified professional midwife' – a certified professional midwife is the national certification that licensed direct entry midwives have. It was noted that a traditional midwife may choose not to be a licensed DEM but can still be designated as a certified professional midwife. RAC agreed that reference to certified professional midwife (CPM) could be removed as supervisory provider.

        - RAC member remarked that under current rules it specifies that there must be adequate numbers of qualified, and where required, licensed or registered personnel on duty. It was noted that many birthing centers use traditional midwives for post-partum care and questioned why reference to CPM should be removed. Staff noted that the section in question is for purposes of supervising the care and services of clients and not just working in a center.
        - Additional question was raised by a RAC member about the definition of supervision and whether a midwife can still be considered 'supervising' if the midwife has left the building. Staff noted that the rule is not about whether a person must be on site or not, rather is about who is professionally responsible for all the client care and services in a center.
    - RAC member remarked that the group should discuss intent in terms of the type of provider who should be able to manage or supervise the services of a birthing center. It was noted that based on discussion, an NP without midwifery specialty cannot manage a center; should the same be true of any physician who does not specialize in maternity care?
        - RAC member suggested that the physician definition be amended to clarify that a physician must have childbirth experience or specialize in maternity care. Staff noted that it needs to consider further including whether it is most appropriate to change the definition or whether such a requirement should be placed elsewhere.
        - RAC further discussed licensing and education requirements for both physicians and nurse practitioners which are significantly different.
- Subsections (3)(a) through (u) specifies the types of policies that a birthing center must have. Discussion:
    - Subsection (3)(h): RAC member questioned risk factor assessment during the antepartum stage if a client may be seeking prenatal care only. For example, client may not be eligible for delivery at birthing center due to risk factors, but the client wishes to have prenatal care performed by birthing center. Subsection (3)(h) specifies that a risk assessment must occur in accordance with Table I which would exclude a client from 'receiving care' at a birthing center. Another RAC member suggested changing 'receiving care' to receiving intrapartum care or performing a delivery. Staff will consider further.
    - Subsection (3)(j): RAC member questioned requirement to consult with a care provider that is credentialed in a hospital. It was suggested that this is too restrictive. Current rule requires only that a birth center have a system delineating how and when the center will seek consultation with clinical specialists. Staff noted that this requirement was added based on adoption of the HERC guidance.
        - RAC member noted that the consultation requirement under HERC has been a real problem and suggested that adoption of the HERC guidance is inappropriate for a facility or a provider type and will restrict the services of the midwife or

center. It was further noted that the Board of DEM has also been working on rule language to ensure that appropriate consultations occur. There needs to be flexibility to allow midwives to make clinical assessments about who the correct consultant may be on a case by case basis.

- RAC member noted that the Board of DEM rules leave the consultation requirement fairly flexible.
- There are many reasons for a provider to seek consultation, but the most frequent problem is when a consult is needed with someone other than a maternity care provider, such as a hematologist.
- RAC member expressed concern that requiring consultation with a provider that has hospital privileges may result in consultation being withheld due to providers that may not support OOH births or care being rendered by a midwife or a birth center. RAC member questioned what the goal of the consultation provision is. If it is to ensure that clients are transferred expeditiously and smoothly, that is already provided for in the rule relating to transfers. If the requirement is to second guess the midwife's risk assessment, then that could be considered discriminatory as these are all licensed professionals with necessary skills and training. If the goal is to ensure that a client understands a doctor's assessment of the risk factors, then that is more of an informed consent issue and recommending consultation to the client rather than requiring it. Some clients already understand the risk factors and a midwife can advise but not require a client to follow-up on a consultation.
- RAC member noted that consultation is a relationship between the midwife and whomever that person is consulting with. If the consultation leads to care being provided elsewhere, that should be considered a referral or transfer. Consultation should be considered a collegial relationship between two experts.
- Staff noted that the purpose of consultation is for the health and safety of the client and newborn. Consultations are a requirement across all spectrums.
- RAC member remarked that Table III should define the nature of the consultation.
- RAC member noted that the last draft of the revised HERC coverage guidance does differentiate between requirements for consultation and transfer of care. Detailed language has not been written yet and will be discussed at the September meeting. Concerns identified in this RAC will be taken back to HERC staff.
- RAC member commented that the level of care of the facility not the clinician might be better in rule. It was suggested that many birth centers already have staff that have hospital privileges so it's unnecessary.
- RAC member shared information about Southern Oregon and noted that a physician may not be the best person to consult. It was suggested that physicians rarely understand the scope of licensed DEMs nor the laws relating to

freestanding birthing centers. Advice received may be out of line with current laws and a lot of time is spent educating the physician. It was recommended that current rule language remain in place.
    - RAC member noted that consultation may not be for the client but the baby as well. Consultation may be sought in other geographic areas if a center is experiencing problems in a certain hospital or region. There are many physicians that support OOH births.
    - RAC member noted that it's important for other members to understand that there are many places where it is difficult to find providers that will provide a consultation for an OOH birth scenario. While consults can be obtained from other geographic areas this may result in difficulties for the client if the consult results in an in-person appointment. Rules should not be drafted that penalize midwives or birth centers when there are documented experiences of bias in areas of the state. The Oregon Perinatal Collaborative has made it a priority to work on home birth and birth center transfer improvement.
    - Staff asked that RAC members not assign any kind of intent to other providers regarding birth care. The role of the RAC is to consider the health and safety of the client and newborn.
- Subsection (3)(n): RAC member questioned what is the definition of prompt availability? A birth center must be ready for any emergency including a disaster. It was noted that there is a separate rule dedicated to emergency preparedness requirements. Promptly available is used currently in rule and it was noted that there are currently no problems with enforcement pertaining to promptly available.
- Paragraph (3)(q)(B): RAC member inquired whether administration of Vitamin K was voluntary. It was noted that the Newborn Care and Screening rule (333-077-0170) directs a birthing center to the requirements in OAR 333-021-0800. These rules provide that a parent may decline administration of vitamin K.
- Subsection (3)(u): It was noted that all health care facilities are required to comply with patient notification requirements. Since a health care facility is defined under ORS 442.015 to include birthing centers, a birthing center must also comply.

ACTION:

1) Find and replace the term "certified nurse midwife" or "nurse midwife nurse practitioner" with "licensed nurse midwife";
2) Revise section (2) by removing reference to nurse practitioner and certified professional midwife;
3) Consider language that clarifies that a birth center may provide prenatal care regardless if client is eligible to have delivery at center;
4) Consider making consultation requirement more flexible so that birthing centers can consult with any clinical specialist as determined necessary and not only with those that have hospital privileges.

OAR 333-077-0100 – Client Care Services

The intent of this rule is to identify the services available to clients and clarify client disclosure requirements and client rights.

- Section (2): RAC member questioned whether "a copy of" included an electronic copy. Staff responded yes.
- Subsection (2)(c): RAC member inquired about intent and whether every medication and every piece of equipment needed to be listed in a client disclosure. It was requested that it be removed since too many details in a client disclosure may not be read. RAC concurred.
- Subsection (2)(f): RAC member suggested that reference to professional liability insurance should be added along with malpractice coverage, i.e. "malpractice coverage or professional liability insurance."
    - Another RAC member questioned whether it was necessary to share that a provider has malpractice coverage.
    - It was noted that the client disclosure information proposed in this rule comes from the Board of DEM current rules. The Board requires that a client be informed whether a midwife does or does not have malpractice coverage.
    - RAC member shared that it is assumed in a hospital setting that all providers have malpractice coverage, but not all midwives do.
    - RAC member shared that professional liability insurance is the most current terminology used.
    - Malpractice is a term that most persons relate to. It was further noted that the term malpractice insurance is used in DEM statutes.
- Subsection (2)(i): RAC member asked that reference to 'consultants and related services and institutions' be removed as it would make the client disclosure too lengthy. The goal is to make sure that clients read the information and not make the disclosure too unwieldy. RAC concurred.
- Subsection (3)(c): RAC member asked that ethnicity, gender identification and sexual orientation be included. RAC concurred.
- Subsection (4)(c): RAC member suggested that when decisions are made about consultation requirements as discussed under 0090 (policies and procedures) that the language be mirrored in this rule.
- Section (5): RAC member suggested that (b) and (c) be removed as there is not a lot of evidence that supports doing weight checks for a woman with a healthy BMI. Additionally, RAC member was unaware of any clinic that completes hematocrit and many clinics and hospitals are doing fewer UAs.
    - Discussion ensued regarding language. The intent is not to require all these tests at every exam rather that the tests be performed at some point.
    - RAC suggested that the language be revised to reference "if indicated." Another RAC member disagreed and suggested that evidence suggests that testing is not necessary. If language is added, it needs to be very general.

- Section (7): It was noted that language specifies "an assessment" which alludes to there being only one and there may be more. It was suggested that the term "an" be removed. RAC concurred.
  - RAC member inquired whether additional language such as comfort measures and physical assistance be included under subsection (7)(a). It was suggested that this not be a minimum requirement rather allow birthing centers the flexibility to identify additional services. The term "consists of" is not all inclusive.
  - Several RAC members suggested removing reference to skin-to-skin contact and breastfeeding attempts under subsection (7)(c). RAC concurred.
- RAC members were encouraged to share possible language with Mellony by E-mail for sections (5) through (7).

ACTION: 1) Revise sections (2) and (3) as indicated above; 2) Mirror consultation language that is adopted in policies and procedures under subsection (4)(c); and 3) RAC members requested to provide feedback on possible text for sections (5) through (7).

Public Comment

Two members of the public shared concerns regarding exclusion of women from birthing centers who would be categorized as vaginal births after cesarean (VBAC). These members of the public shared their personal experiences with VBAC. It was suggested that current data does not support the exclusion. It was also suggested that women may choose to have an unassisted birth at home if restrictions are not reconsidered.

Sharron Fuchs reiterated previous suggested changes that were shared at the May 30th RAC meeting and additional suggestions.

- 0010 – Definition of physician should include chiropractic physicians.
- 0090(3)(a) – Types of procedures that are prohibited in a birth center should be specified (i.e. vacuum extractions or forceps).
- 0090(3)(b) – All providers must have privileges (no walk-ons).
- 0100 – Both services provided and not provided should be listed.
- 0100(2)(f) – Statute for DEMs specifies malpractice coverage, so it should be kept in rule. It was further noted that some places have insisted that clients sign a mandatory arbitration agreement which is improper and inappropriate.

Debbie Cowart, Owner of Growing Family Birth Center in Lebanon, shared concerns about the HERC guidelines being adopted in the proposed rules and also suggested that women may choose to have an unassisted birth at home if the guidelines are adopted for birthing centers.

Next Steps

The next RAC meeting will begin at 333-077-0110 admission discharge. There are number of rules remaining that may take additional time including the physical environment requirements and the proposed tables.

Jason Gingerich shared that the HERC Evidence-based subcommittee will be discussing the risk factor guidance at its September 12th meeting and will be posting the document for public comment shortly after. It was noted that best way to comment on the guidance is during the

public comment period to allow staff to research and prepare a response. Public comment will be reviewed at the December 5th meeting and the full committee will make final decisions in January or March 2020.

D. Selover noted that the Birthing Center RAC may need to reconvene after the HERC guidance is finalized.

ACTION: Mellony Bernal will be sending out a meeting doodle poll to work on scheduling the next RAC meeting.