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**Birthing Center Rule Advisory Committee**
**July 21, 2021**
**9:00 a.m. via Zoom**

| RAC MEMBER ATTENDEES | |
|---|---|
| Colleen Forbes | Former chair, Board of Direct Entry Midwifery |
| Danielle Meyer | Oregon Association of Hospitals and Health Systems |
| Desiree LeFave | Bella Vie Gentle Birth |
| Hermine Hayes-Klein | Oregon Association of Birth Centers |
| Jennifer Gallardo | Andaluz Waterbirth Center |
| Karen DeWitt | Oregon Association of Naturopathic Physicians |
| Kaylyn Anderson | Consumer |
| Kelsey Fischer (for Silke Ackerson) | Oregon Midwifery Council |
| Laura Erickson | Alma Midwifery Services |
| Lynette Pettibone | American Association of Birth Centers |
| Margy Porter | Bella Vie Gentle Birth Center |
| Michelle Zimmerman-Pike | American College of Nurse Midwives |
| Ruby Jason | Oregon State Board of Nursing |
| Stefanie Rogers | Providence Health Systems |
| Willa Woodard | Rogue Birth Center |
| **OTHER INTERESTED PARTY ATTENDEES** | |
| Kori Pienovi | Women's Healthcare Associates' Midwifery Birth Center |
| Sharron Fuchs | Public Citizen |
| **OHA Staff** | |
| Anna Davis | PHD-Health Facility Licensing & Certification |
| Dana Selover | PHD-Health Care Regulation & Quality Improvement |
| Lacey Martinez | PHD-Health Facility Licensing & Certification |
| Mellony Bernal | PHD-Health Care Regulation & Quality Improvement |
| Samie Patnode | PHD-Health Licensing Office |

## Welcome and Overview

Mellony Bernal welcomed Birthing Center Rule Advisory Committee (RAC) members and reviewed housekeeping items. RAC members, OHA staff and members of the public introduced themselves.

Dana Selover thanked RAC members for their patience as OHA staff continue to respond to the COVID-19 pandemic, wildfires, and the 2021 legislative session. A quick refresher on what the RAC has done was shared:

- The core rule text was reviewed. Staff tracked action items and have developed responses which the RAC began to review at the August 3, 2020. After the risk factor tables are completed, staff will bring back to complete the review.
- The RAC has been reviewing absolute risk factors in Table I. It was noted that the proposed Tables I through III were developed based on the Health Evidence Review Commission's (HERC) Planned Out-of-Hospital Birth Coverage Guidance, dated 11/12/2015. It was further noted that the Board of Direct Entry Midwifery (DEM) and the HERC have since updated rules and guidance. Staff are conducting polls on whether the risk factor should remain as an exclusion or move to a consultation requirement. D. Selover noted that there are some risk factors that will need to be further discussed and which will occur late.
- The RAC reviewed the physical environment rule which was initially based on the Facility Guidelines Institute standards for freestanding birthing centers. Based on comments received from the RAC, the rule was amended and redistributed to RAC members for consideration. Additional follow-up on the proposed changes will occur later.

It was noted that to make it through all the tables, D. Selover suggested meeting more frequently but for shorter periods of time. The goal is to have final rules in place by end of June 2022.

**Review of August 3, 2020 Meeting Notes**

The August 3, 2020 notes were shared. D. Selover noted that half the meeting was devoted to working through the initial responses to action items and the other half to discussing risk factors and conducting straw poll. Depending on how quickly meetings get scheduled in the future, meeting minutes may be delayed. It was noted that state offices are opening in September but it not clear when in-person meetings will occur. RAC members located further away will likely want to continue to participate remotely and staff need to consider how a hybrid meeting model will work.

**Risk Factor Table I – Risk Factors for EXCLUSION AT ADMISSION**

**CURRENT PREGNANCY COMPLICATIONS**

**Oligohydramnios/Polyhydramnios**

Dana asked RAC members for feedback. Discussion:

- RAC member suggested that each of the factors be discussed separately and not grouped together as they are very different. D. Selover asked RAC members whether they had comments on whether to keep as an exclusion. RAC member stated she would defer to others but noted that she has seen many neonates born after concerns of oligohydramnios or polyhydramnios that are normal. She suggested it be listed under consultation requirement. It was further noted that there are different degrees of these conditions that may be a clear indication for a hospital delivery.
- RAC member agreed with separating the conditions for discussion. RAC member further stated that if the water breaks prior to a biophysical profile it could be low even if there were no previous concerns.
- Discussion ensued amongst RAC members about whether additional text is necessary to clarify that it does not apply if someone's water breaks and therefore fluid is low, and onset of labor could occur just after that.

- D. Selover remarked that it is assumed that water measurement occurs before water breaks. RAC member responded 'in theory' but some pregnant persons do not have a biophysical profile (BPP) until 41 weeks, water breaks, and then BPP would show as low.
- RAC member stated that a potential issue is it may discourage providers from conducting a BPP after membrane was ruptured. Additional clarity is needed as someone may have borderline 'oligo' due to dehydration which may resolve within 24-48 hours. Moving the risk factor to consultation is an option, but more definition is needed.
- RAC member agreed with separating the conditions and agreed that normal births may occur based on degrees. Also agreed that 'oligo' exclude rupture of membranes and move to consult.
- HLO staff via the chat noted that 'poly' is under antepartum consult.
- RAC member stated via chat to define levels for 'oligo' and 'poly.' D. Selover noted that the downside of putting more definitions around clinical terms in rule, means that it is more difficult to make changes if clinicians or science suggest something different, and especially if it is something that will be moved to consultation. Two RAC members remarked via chat concurring that no numbers should be specified.
- RAC member stated via chat that both 'poly' and 'oligo' are requirements for consult on current LDM rules.
- RAC member stated via chat that the state of Washington requires consult.
- RAC member noted via chat that HERC has the conditions listed as a transfer.
- Several RAC members stated via chat that the conditions do not need to be separated if moving to consultation.
  - Two other RAC members agreed via chat but with the clarification that it excludes rupture of membranes.
  - Another RAC member stated via chat that rupture of membranes does not need to be stated since this would be taken into consideration during the consult.
  - D. Selover asked whether rupture of membranes isn't already considered under the clinical definition in 'olio?' The consult takes everything into consideration.
  - RAC member remarked that rupture of membrane can occur on the same day that someone has a BPP and as such would have 'oligo.' This should not require a consult because 'oligo' was due to the rupture and the pregnancy person would likely go into labor same day. Requiring a consult in this scenario would be inappropriate. D. Selover questioned again whether this isn't already common practice and taken into consideration where a provider is more concerned about 'oligo' in last trimester versus around time of birth.
  - RAC member stated that additional clarification is needed to protect the provider due to increased scrutiny.
  - RAC member suggested via chat that they would agree with consult if language is updated to consult for 'oligo' except in cases with documented rupture of membrane.

<u>POLL: Retain Oligohydramnios/Polyhydramnios (excluding rupture of membrane) as an absolute risk factor? Results:</u>

- 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.
- 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.
- 31% - 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.
- 62% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

POLL: Move Oligohydramnios/Polyhydramnios (excluding rupture of membrane) to consultation requirement? Results:

- 54% - I can say an enthusiastic yes to the recommendation (or action).
- 38% - 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.
- 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 asked before proceeding with additional polling to discuss how consultation is being defined in the draft rules which may affect the vote of birthing center members. It was suggested that historically the rules defined consultation in a way that ultimately leaves the decision making with informed consent to the providers and their clients. It was asked whether the rules specify that the consult must be with a provider with hospital privileges and are the birthing centers obliged to follow the in-hospital providers recommendation?

Staff displayed the following draft language both on screen and in the chat, which was developed in response to comments provided by RAC members in previous meetings:

**333-077-0125**

**Risk Status Assessment and Consultation Requirements**

(1) A birthing center shall assess a client's risk status throughout pregnancy, labor and delivery to determine if an out-of-hospital birth is appropriate based on the risk factor criteria specified in Tables I and II, or any consultation conducted based on the criteria specified in Table III.

(2) A risk assessment shall be performed within 14 calendar days of the initial prenatal care visit and updated throughout the pregnancy, labor, and delivery.

(3) Appropriate referral or transfer to a higher level of care shall occur if the client, fetus, or newborn meet any of the risk factor criteria identified in Tables I or II.

(4) A birthing center shall consult with a provider of maternity care who is credentialed to admit and manage responsibilities in a hospital, or other specialty provider, if a client or fetus meet any of the consultation criteria specified in Table III.

(a) A birthing center shall include the client during the consultation, if possible. If the client is unable to participate during the consultation, the birthing center shall notify the client about all recommendations made by the consultant.

(b) The birthing center shall document the consultation, recommendations made, and discussions with the client.

(c) If a consultation determines that an out-of-hospital birth is no longer acceptable due to the client meeting risk factor criteria specified in Tables I or II, the birthing center shall refer or transfer the client to an appropriate health care provider or facility.

(5) Notwithstanding sections (3) and (4) of this rule, if a risk assessment or consultation determines that an out-of-hospital birth is no longer acceptable, a birthing center may continue to provide prenatal care to a client, if the birthing center obtains the client's informed consent including at a minimum:

(a) The client is informed of all potential risks and provides consent to continue to receive prenatal care;

(b) The client acknowledges that birth will be planned at a hospital;

(c) Documentation of subsections (5)(a) and (b) of this rule is noted in the client's medical record.

Staff also displayed and posted in the chat the Board of DEM's current OAR language relating to consultation:

OAR 332-025-0021

(14) "Indication for Consult" means a condition or clinical situation that places a birthing person or newborn at increased obstetric or neonatal risk but does not automatically exclude a birthing person or newborn from a community birth or midwifery care.

(15) When a birthing person or newborn present with one (1) or more indications for consult the LDM must:

(a) Arrange for transfer of care; or

(b) Comply with all the following:

(A) Consult with an Oregon licensed health care provider, as defined in OAR 332-025-0021(20) and (21) of this rule, who is experienced and knowledgeable about the indication for consult unless a different Oregon licensed health care provider is otherwise stated specifically within this rule;

(B) Communicate to the birthing person the recommendations given by the consulting Oregon licensed health care provider if the birthing person was not present at the consultation;

(C) Obtain informed consent in accordance with OAR 332-025-0120;

(D) Make a plan with the birthing person about the indication; and

(E) Document the recommendations, consultation, discussion, informed consent, and plan.

…

(21) For the purpose of this rule “consultation” means a dialogue for the purpose of obtaining information or advice, with an Oregon licensed health care provider who has direct experience handling complications of the risk(s) present, as well as the ability to confirm the indication for consult, which may include, but is not limited to confirmation of a diagnosis and recommendation(s) regarding management of medical, obstetric, or fetal problems or conditions. Consultation may be by phone, in person, or in writing.

(22) For the purpose of this rule “Oregon licensed health care provider” means a physician or physician assistant licensed under ORS 677, a nurse practitioner who is licensed as a nurse midwife under ORS 678 or nurse practitioner licensed under ORS 678, a naturopath licensed under ORS 685, or a licensed direct entry midwife licensed under ORS 687.

Discussion:

- D. Selover noted that moving the discussion from risk factor polling to defining consultation is going to slow down process, and while staff are happy to consider additional input, staff will not be able to finalize language on the spot.
- Based on language displayed, RAC member asked what if the client and provider do not agree with the consultant's recommendation because of bias. It was further questioned whether insurance would cover.
- RAC member stated that section (4) is a problem because it requires consultation with a provider of maternity care who is credentialed to admit and manage responsibilities in a hospital and hospital based providers have little knowledge or experience with out-of-hospital or birthing center births and the things necessary to make it safe. It was also stated that some of the risk factors that would require consultation would be best done with a hospital based provider because of the nature of the risk factor but for some other risk factors it is more sensible for a birthing center or out-of-hospital provider to consult with another out-of-hospital provider that has experience with that risk factor. Turning to a hospital-based provider with no relevant knowledge or experience is not a useful exercise. Staff responded that there is additional language that would allow other specialty providers for purposes of consultation not just providers with hospital privileges. RAC member stated it would be helpful to further define who other specialty providers would include.
- RAC member stated that the language in subsection (4)(c) is vague and the passive voice should be removed. How and who is making determination needs to be clarified. If the ultimate determination is made by the out-of-hospital provider in collaboration with the client, and the client's right of informed consent, then the Oregon Association of Birth Centers (OABC) would accept that. Any language that could be interpreted that the hospital-based provider makes the decision would not be acceptable.
- RAC member had further concerns with section (5) where based on informed consent a birthing center can provide prenatal care, the OABC position would be that ultimately as long as the client remains within scope for the birthing centers, the client can make an informed choice on how they want to proceed. It was asked that that the language be amended to remove reference to "prenatal" and specify provide care to the client.
- RAC members via chat expressed concern about continuing to vote on risk factors when it is not clear what consultation is or disagree with current draft language.
- RAC members via chat stated that the Board of DEM consultation language is defined well, and most birthing centers agree with the DEM language.
- RAC member stated via chat that it is necessary to document the consultation, the recommendations and not following the recommendations to document why the recommendations are not being considered/followed.
- D. Selover noted that out-of-hospital providers are still subject to their licensing board rules and must follow such rules regardless if practicing in a birthing center or in a client's home.
- HLO staff shared that if a consult is necessary, the midwife must consult with a defined provider (physician or physician assistant licensed under ORS 677, a nurse practitioner who

is licensed as a nurse midwife under ORS 678 or nurse practitioner licensed under ORS 678, a naturopath licensed under ORS 685, or a licensed direct entry midwife licensed under ORS 687), obtain a recommendation which is communicated to the birthing person if not present for the consultation. The midwife can move forward with the plan with informed consent from the client.

- D. Selover asked RAC members to vote via chat how many would like to not move forward with the risk factor discussion and discuss consultation instead. Majority of RAC members via chat chose consultation for further discussion.
- D. Selover recessed the meeting until 10:30 a.m. to allow staff time to consider consultation language.

**OAR 333-077-0125**
**Risk Status Assessment and Consultation Requirements**

The meeting was reconvened at 10:35 a.m.

Staff re-displayed the proposed rule on risk assessment and consultation (OAR 333-077-0125) and in the chat posted the Board of DEM OAR definition for 'consultation' and 'Oregon licensed health care provider.'

OAR 332-025-0021
(21) For the purpose of this rule “consultation” means a dialogue for the purpose of obtaining information or advice, with an Oregon licensed health care provider who has direct experience handling complications of the risk(s) present, as well as the ability to confirm the indication for consult, which may include, but is not limited to confirmation of a diagnosis and recommendation(s) regarding management of medical, obstetric, or fetal problems or conditions. Consultation may be by phone, in person, or in writing.
(22) For the purpose of this rule “Oregon licensed health care provider” means a physician or physician assistant licensed under ORS 677, a nurse practitioner who is licensed as a nurse midwife under ORS 678 or nurse practitioner licensed under ORS 678, a naturopath licensed under ORS 685, or a licensed direct entry midwife licensed under ORS 687.

**333-077-0125**
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(2) A risk assessment shall be performed within 14 calendar days of the initial prenatal care visit and updated throughout the pregnancy, labor, and delivery.
(3) Appropriate referral or transfer to a higher level of care shall occur if the client, fetus, or newborn meet any of the risk factor criteria identified in Tables I or II.
(4) A birthing center shall consult with a provider of maternity care who is credentialed to admit and manage responsibilities in a hospital, or other specialty provider, if a client or fetus meet any of the consultation criteria specified in Table III.
(a) A birthing center shall include the client during the consultation, if possible. If the client is unable to participate during the consultation, the birthing center shall notify the client about all recommendations made by the consultant.
(b) The birthing center shall document the consultation, recommendations made, and discussions with the client.
(c) If a consultation determines that an out-of-hospital birth is no longer acceptable due to the client meeting risk factor criteria specified in Tables I or II, the birthing center shall refer or transfer the client to an appropriate health care provider or facility.
(5) Notwithstanding sections (3) and (4) of this rule, if a risk assessment or consultation determines that an out-of-hospital birth is no longer acceptable, a birthing center may continue to provide prenatal care to a client, if the birthing center obtains the client's informed consent including at a minimum:
(a) The client is informed of all potential risks and provides consent to continue to receive prenatal care;

(b) The client acknowledges that birth will be planned at a hospital;
(c) Documentation of subsections (5)(a) and (b) of this rule is noted in the client's medical record.

D. Selover noted that the issues before the RAC are to discuss the following:
1) Who can provide consultation;
2) Who and how is ultimate determination made based on consultation.

Discussion:

- RAC member commented that if the birthing center rules align with the definitions of the Board of DEM for consultation as displayed in the chat, birthing centers would be supportive. D. Selover noted that for current discussion purposes only, staff will consider approving the definition of Oregon licensed health care provider adopted by the Board of DEM for purposes of who can provide consultation for purposes of exclusion. The consulting provider may not be associated with the birthing center seeking the consult. In terms of the definition of consultation, the program needs additional time to consider the language and the potential consequences of adopting. For example, an LDM may not be able to confirm a medical diagnosis like other providers depending on the risk factors.
- D. Selover asked neonatologist for feedback on the proposal. RAC member supported the proposed provider definition with the caveat that it cannot be someone from within the birthing center due to potential bias. It was noted that all providers need to continue to work on patient centered relationships and work towards how to best serve the patient and meeting the patients needs regardless of the setting.
- RAC member via chat asked whether the external requirement would include MDs and CNMs who are affiliated with the birthing center? D. Selover indicated that the program will need to consider this.
- RAC member stated there are two primary concerns with the proposed draft language: 1) only consulting with providers who have hospital privileges (which would be addressed by using the DEM provider definition); and 2) the outcome of the consultation (which should be resolved before moving forward.) It was stated that if the decision is that the birthing center must follow the consulting provider's recommendation, then the birthing centers would not support. D. Selover reiterated that that the program has an obligation in statute to adopt rules for birthing centers for clients with low risk birth and as such, the program needs additional time to consider how to address circumstances where there is a difference of opinion on whether the birth is still considered low risk based on the consultation. RAC member responded that the issue is when does a client come out of the low risk box. The absolute risk factors specified in the tables are those factors that would require a client be transferred; however, the consultation table is for clients that don't meet the absolute criteria but have clinical issues that need to be considered further. RAC member further stated that the regulations should be written so that an out-of-hospital provider's 'opinion' does not supersede the birthing center provider's experience and give power to the consulting provider to decide low risk which gives the consulting provider the power to contradict the rules and make a determination of who gets to access out-of-hospital birth with a competitor. Clarifying consultation is therefore necessary for continuing risk factor discussions. D. Selover noted that while there may be a differing opinion it does not mean that a consulting provider does not understand risk and birth regardless of the setting.

- RAC member stated that there are very few providers in rural Oregon that can perform consultations and all of which are entirely biased. Many hospital-based rural providers do not believe any out-of-hospital birth is safe. RAC member urged program to carefully consider unintended consequence of allowing a biased provider to make the final decision.
- RAC member echoed thoughts of previous RAC members that it would be inappropriate for the consultant to be the deciding factor on whether an out-of-hospital birth is appropriate. RAC member further stated that while a consultant may be an expert on a specific condition or risk factor, they are not an expert on out-of-hospital birth and not an expert on midwife scope of practice and the tools and equipment a midwife has access to. She further stated that the midwife is the out-of-hospital birth expert. Example provided of a consultant who recommended in hospital birth even though no specific risks or consequence were given that might impact the baby that couldn't have been managed by the midwife. The consultant stated that she recommended all births, even low risk, to be done in a hospital in case something happens. The autonomy of the providers is taken away as well as that of the client. RAC member further stated that subsection (5)(a) should be edited as there is no possible way to list every possible risk. Consider replacing with the client is reasonably informed of likely severe or common risks.
- RAC member stated via chat that some birthing centers in Oregon are near very biased hospital providers and who have acted very unprofessional.
- RAC member stated via chat that the comment that “high risk” birth only happens in hospitals implies that only hospital providers would know how to assess that risk and misses the point. A uterine scar is a risk that both in-hospital and out-of-hospital providers understand and manage under Oregon law. Some providers would consider the existence of a uterine scar “high risk,” others would not. What is important to OABC is ensuring that the hospital providers are not given the power to define who is “high risk” in a way that contradicts scope of practice for OOH midwives and birth centers.
- RAC member stated that she wanted to make sure that the language would exclude the use of hospital-based certified nurse midwives or physicians that their birthing center consults with (e.g. obstetricians, fetal maternal medicine doctors) across the Portland metro area. Provider types each have their own professional scope of practice and rules. D. Selover remarked that the exclusion language may need to be considered further.
- RAC member suggested in section (5)(a) to use the term 'material risks' as noted in ORS 677.097.
- RAC member stated via chat that sometimes midwives call to consult with hospital providers who feel a level of confidence with a risk factor that is not appropriate for out-of-hospital birth. Midwives have to be able to be trusted to determine what is appropriate.
- RAC member stated via chat that a consult is for more information, but the patient and midwife as long as practicing within their scope should make the final decision.

D. Selover asked the RAC based on the discussion so far whether the RAC wants to continue with risk factor tables or continue with consultation discussion. A majority of the RAC members voted to continue with the consultation discussion.

The following comments on the proposed rule were discussed:

- Section (1) – A birthing center shall assess a client's risk status throughout pregnancy, labor and delivery to determine if an out-of-hospital birth is appropriate based on the risk factor criteria specified in Tables I and II, or any consultation conducted based on the criteria specified in Table III.
  - No comments provided.
- Section (2) - A risk assessment shall be performed within 14 calendar days of the initial prenatal care visit and updated throughout the pregnancy, labor, and delivery.
  - RAC member stated that to make a decision about risk, often times records must be obtained which may take additional time. The time frame should be more ambiguous but state that it must be done during early part of care.
  - Staff noted that a risk assessment is an on-going process and for purposes of this rule a clear timeline is needed for the initial determination. As additional information is obtained it would be expected that records are updated and documented.
  - RAC member stated via chat that 21 days is more appropriate as it could take 14 days to acquire previous records. Other RAC members via chat concurred with 21 days.
  - RAC member indicated that the rule states the "birthing center" shall assess and should be modified to indicate who is actually doing the assessment. D. Selover noted that this is likely addressed by other rule language including policies and procedures and defining clinical staff and clinical provider.
- Section (3) - Appropriate referral or transfer to a higher level of care shall occur if the client, fetus, or newborn meet any of the risk factor criteria identified in Tables I or II.
  - RAC member clarified that Table 1 is risk factors for exclusion at admission and Table 2 is risk factors or complications for transfer to hospital during intrapartum or postpartum care. The RAC member indicated that additional clarification is needed to ensure the correct interpretation of "exclusion at admission" - is exclusion at time of labor?
  - RAC member via chat stated that she reads the language of (3) to interface with the tables, which only require providers to refer or transfer after the risk factor is identified, which might only happen on admission.
  - HLO staff noted that the Board of DEM rules, OAR 332-025-0021 (1) through (6) discuss ongoing risk, timing and resolved indications.
  - RAC member commented that a lot confusion is around whether "at admission" means at time of care or at time of labor and additional clarification should be considered.
  - D. Selover noted that the program may issue interpretive guidance for clarification purposes.
- Section (4) - A birthing center shall consult with a provider of maternity care who is credentialed to admit and manage responsibilities in a hospital, or other specialty provider, if a client or fetus meet any of the consultation criteria specified in Table III.
  (a) A birthing center shall include the client during the consultation, if possible. If the client is unable to participate during the consultation, the birthing center shall notify the client of all recommendations made by the consultant.
  (b) The birthing center shall document the consultation, recommendations made, and discussions with the client. (document participants in the consultation, information shared

with the consulting provider, recommendations made, and discussions with the client) (decisions made by the client).
(c) If a consultation determines that an out-of-hospital birth is no longer appropriate due to the client meeting risk factor criteria specified in Tables I or II (consider removing reference to tables I and II), the birthing center shall refer or transfer the client to an appropriate health care provider or facility.

- D. Selover noted that as discussed previously the program will consider adopting the Board of DEM definition for a provider who can consult.
- RAC member via chat recommended that section (4) be amended to align with Board of DEM rules.
- RAC member via chat stated that the language should be consistent with Oregon State Board of Nursing for nurse practitioners.
- RAC member remarked that for purposes of subsection (4)(c) the Board of DEM rules are better. A client must be allowed to make an informed choice on whether to proceed with an out-of-hospital birth despite consultation recommendations.
- RAC member stated that the current language in subsection (4)(c) needs to be revised to note the client's choice.
- RAC member via chat recommended revising subsection (4)(b) indicating document the consultation, recommendations made, discussions with and decisions made by the client.
- Staff recommended via chat suggested edits for subsection (4)(b) including, 'to document participants in the consultations, information shared with the consulting provider, recommendations made, and discussions with the client.' Staff asked whether any RAC members had any concerns about with existing Board of DEM rule language in section (15) of OAR 332-025-0021.
- RAC member via chat indicated that paragraphs (D) and (E) in subsection (15)(b) of the Board of DEM rules is loved.
- RAC member remarked that a risk factor in Tables I or II are considered a high-risk birth and as such is an indication to transfer. In table III, the risk factors are a grey area and if after a consultant the client is still low risk within the midwife's scope of practice, a plan can still be made to birth in the birthing center and would solve the problem with people working in more rural areas where a doctor may be biased. D. Selover noted that there is one situation where language is needed for absolute risk factors (e.g. molar pregnancy) and the other situation where there is a grey zone. The Board of DEM language works for the consultation but not necessarily for the absolute exclusion. RAC members disagreed via chat and suggested that section (15) Board of DEM language works.
- D. Selover noted that if a consultation results in a finding of a risk factor in Table I or II, the client must be transferred. If the consultation, based on risk factors in Table III, results in a recommendation that is not in Table I or Table II, information about risks must be shared with the client and to the people providing care, then subsection (15)(b) language would apply. Language would need to be clarified.
- RAC member suggested that additional language referring to tables I or II in subsection (4)(c) is redundant given language in section 3. It was reiterated that RAC members want to address what is the purpose of the consultation and who is the decision maker. She further supported the Board of DEM language. D. Selover

responded with an example of a new finding that was not previously known but may have been caught by a consultant. RAC responded that it still doesn't seem relevant regardless of source as it would still require a transfer.
    - RAC member stated via chat that it "Allows for informed consent of patient if in that gray area. With all the info from consulting provider and their midwife."
    - RAC member stated via chat that she would like clarification on whether the passive voice will be removed since the passive voice removes the person who is acting from the sentence and is exactly what is needed to determine who is making the decision.
- (5) Notwithstanding sections (3) and (4) of this rule, if a risk assessment or consultation determines that an out-of-hospital birth is no longer appropriate, a birthing center may continue to provide prenatal care to a client, if the birthing center obtains the client's informed consent including at a minimum:
  (a) The client is informed of all potential risks and provides consent to continue to receive prenatal care;
  (b) The client acknowledges that birth will be planned at a hospital;
  (c) Documentation of subsections (5)(a) and (b) of this rule is noted in the client's medical record.
    - RAC suggested via chat to revise section (5) to specify 'common and/or significant risks.'
    - Staff suggested considering "known potential risks and likelihood of occurrence."
    - RAC member stated via chat that "likelihood of occurrence" can be tricky; percentages are public health figures and may not map to a specific client.
    - RAC member suggested via chat that subjection (5)(b) be amended to 'the client acknowledges that the birth has been recommended to occur at the hospital' since some clients may look for a different provider and/or birth site.
    - RAC member via chat agreed with reference to 'material risk.'

D. Selover stated that the core of the rule is that a consultation is needed, the findings of the consultation, and that the client is informed and involved in the conversation.

Staff noted the time of 12:02 p.m. and D. Selover indicated that the program will work on this rule language further. Staff will send another meeting poll to identify a couple of meeting dates.