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Birthing Center Rule Advisory Committee
October 4, 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
Michelle Zimmerman-Pike	Oregon Affiliate of the American College of Nurse Midwives
Sarah Wickenhagen	Oregon State Board of Nursing
Silke Ackerson	Oregon Midwifery Council
Tierra Salmón	Birth Justice Policy Committee
Wendy Smith	Legacy Emanual Medical Center
Willa Woodard Ervin	Rogue Birth Center
OTHER INTERESTED PARTY ATTENDEES	
Carrie Hertzler	Public
Debbie Cowart	Growing Family Birth Center
Dele Ogunleye	Andaluz Waterbirth Center
Elle Molokwu	Birth Justice Policy Committee
Laura Wiegand	Andaluz Waterbirth Center
Mark Buchholz	Pacificsource
Miriam Herrmann	Trillium Community Health Plan
Ray Gambrill	AllCare Health
Rebeckah Orton	Astoria Birth Center and Family Medicine
Sharron Fuchs	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
Kristty Zamora-Polanco	External Relations Division – Innovator Agent
Mellony Bernal	PHD-Health Care Regulation & Quality Improvement
Rebecca Long	PHD-Emergency Medical Services & Trauma Systems Program

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.

March 8, 2022 Meeting Notes

RAC members were asked to submit any comments on proposed changes to the March meeting notes to Mellony Bernal by e-mail.

Overview of Agenda

M. Bernal reviewed agenda. Staff will provide an update on committee activity to date and then begin reviewing three of the last four risk factors that had been deferred to discuss in the future [gestational age, non-cephalic presentation, multiples and vaginal birth after cesarean (VBAC).] The goal is to finish discussions on gestational age, non-cephalic presentation and multiples and then schedule another meeting to discuss VBACs.

Birthing Center Rule Advisory Committee Update

Dana Selover welcomed everyone and noted there are two additional subject matter experts that have been added to the RAC in response to HB 2993 which passed in 2021; Wendy Smith and Tierra Salmón.

The following overview was provided:

- 16 RAC meetings have occurred since May 2019. The birthing center administrative rules were initially adopted in 1985, amended in 1990 and risk factor tables adopted in 2006. Pulse ox screening was added in 2014. No other changes have occurred in the last 16 years.
- Meeting agendas and meeting notes for all prior meetings are now available on the web at https://www.healthoregon.org/hcrgirules.
- Future meeting notes and public hearing information will be posted on the web page.
- The RAC has completed initial review of main rule text as well as follow-up review of amended rule text.
- Risk factor Table I (exclusion at admission) and Table II (transfer to hospital) have been completed with exception of the four risk factors noted previously.
- Notices of proposed rulemaking including the public hearing will be posted and the Division will consider both written and oral comments. There will be plenty of opportunity for persons that are not on the RAC to comment on the proposed rules.
- The meeting today will focus on three of the four remaining risk factors that had been deferred from previous conversations – Multiple gestation, non-cephalic presentation, and gestational age.
- Remaining work for this RAC includes:
  - Discussing vaginal birth after cesarean (VBAC)

  - Reviewing revised consultation requirement Table III
  - Reviewing the Statement of Need and Fiscal Impact, as well as consider how the rules will impact racial equity in Oregon
- The Division will be convening a community meeting to focus on Black, Indigenous, and People of Color communities; seeking review of the rules by the Department of Justice; and then will be filing a notice of proposed rulemaking with the Secretary of State
- Information about HB 2993 was shared including requirements of the 2021 Oregon Law, Chapter 463 and it was noted that the purpose of the community meeting will be to seek input on all of the proposed rule text and risk factor tables from Black, Indigenous, and People of Color communities.

Elle Molokwu, participating on behalf of Tierra Salmón, introduced self and represents the Birth Justice Policy Committee that is working with lawmakers on policy changes that are needed for black and brown bodies. E. Molokwu is a full spectrum Doula (birth, postpartum, and death) who also is a patient representative educating patients about things that happen during birth.

Dr. Wendy Smith is an OB/GYN hospitalist who works at Randall Children's Hospital at Legacy Emanuel Medical Center. W. Smith is a physician representative on the Oregon Board of Direct Entry Midwifery since 2013 who takes pride in working with community midwives to make Oregon the safest place possible for birthing people.

Follow-up - Information on Birthing Center OARs:

- 1985: Initial rules adopted
- 1990: Rules were amended adopting administrative licensing procedures; expanding policies and procedures; adding medical record requirements including consultation with Registered Record Administrator or Accredited Records Technician; and adding neonatal CPR requirements and infection control measures.
- 2006: Rules were amended adopting risk factor criteria; requiring policies and procedures to meet North American Registry of Midwives Standards; amending elements of policies and procedures relating to emergency transfers and client orientation and education; amending Vitamin K administration and newborn screening; updating infection control guidance; and amending physical environment requirements.
- 2008: Emergency preparedness requirements adopted.
- 2014: Pulse oximetry screening requirements adopted.

Risk Factor Table I – Risk Factor Criteria for Exclusion at Time of Admission

D. Selover open discussion and reminded RAC members that the rules for a licensed birthing center facility are focused on the statutory requirement that births must be low risk. Requirements from the Board of Direct Entry Midwifery (DEM) rules, guidance from the Health Evidence Review Commission (HERC) and the compliance indicators from the Commission for the Accreditation of Birth Centers (CABC) were shared for each risk factor. It was noted that the Birthing Center OARs are specific to the facility, therefore whomever has privileges at the facility would be required to comply with the proposed rule even if rules relevant to the provider's license permit a broader scope of practice. RAC member expressed concern that this does not make sense.

Gestational age – preterm (<37 weeks, 0 days) or postdates (>41 weeks+6 days)

The proposed requirement is that gestational ages less than 37 weeks, 0 days or greater than 41 weeks, 6 days will require transfer to hospital. It was further noted that if a birthing person is in active labor at the applicable gestation dates than the transfer requirement may not apply.

Discussion:

- RAC member remarked that the current regulation, allowing delivery in the birth center at 36 weeks should be retained. Gestational age is handled on a case by case and depends on how sure the birthing person is about the conception date and the birthing person's comfort level with the higher possibility of a transfer after delivery. The RAC member indicated that there is no evidence in Oregon that the current rule is not working. Between 36 to 37 weeks the biggest concern is an increased risk of respiratory distress syndrome, which only affects about 5% of babies and is much less likely for a baby at 36 weeks, 6 days versus 36 weeks, 0 days.
- RAC member stated that one of the things that makes the risk factors being discussed today different than those previously discussed, is that these are risk factors that represent an increased risk of potential pathology but may be healthy and normal. It was further stated that pregnancies or labors with these complications face an increased risk of negative outcomes no matter how or where the baby is delivered, and there are increased risks associated with non-intervention or increased risks associated with induction or surgical delivery. RAC member further stated that while Oregon law defines a birthing center as a place licensed for the primary purpose of low-risk deliveries, that secondary purposes should be considered including deliveries that involve additional complications or risks, such as continuing to serve women based on the current gestational age rule criteria to allow vaginal birth of twins and breech babies. As indicated previously, whether to attempt birth at a birthing center in these situations should be handled on a case-by-case basis. Citizen rights should be upheld and protected. The Oregon Association of Birth Centers (OABC) has not identified any evidence of negative outcomes associated with a serving pregnant persons who go into labor between 36 and 37 weeks, or after 42 weeks to 43 with a reassuring non-stress test.
- RAC member stated agreement with the 36 to 37 weeks criteria.
- RAC members via Chat agreed with maintaining 36 weeks.
- RAC member indicated support for current rule language (greater than 42 weeks but less than 43 weeks unless there is an abnormal non-stress test or other non-reassuring fetal surveillance testing.) While there are some increased risks, there are also benefits to a baby the longer they gestate up to at least 40 weeks. There are very small increases in risk, usually a half percent, which is not substantial enough to not allow a pregnant person to labor. It was further stated that vulnerable populations, including women of color, face increased risk and increased negative outcomes when they are forced to change providers late in the pregnancy which is what would happen if the birthing person went into labor outside the limits specified.
- RAC member stated that post-dates is an important area to allow birthing people to choose with informed choice whether they give birth and what course of care they want. RAC member remarked that they are seeing a greater restriction in choice and greater pressure to induce in the hospital when someone passes their due date. With good fetal surveillance, it's important that community birth be maintained as an option for people who want to wait for physiologic labor.

- RAC member via Chat indicated that even though risks may be slightly increased, there may be an increased risk for sending people to a hospital for care (especially considering equity issues that exist in healthcare.)
- RAC member stated that persons of color with person of color providers who must change providers because of late gestation and must transfer to a hospital which might not be the safest place for them, creates more of a problem by creating an environment of trauma for those patients. It was further stated that people tend to focus on the scientific facts about what could happen and not looking at how those choices can have long term effects for black and brown bodies through the whole course of pregnancy including postpartum.
- RAC member stated that birthing persons are being sent to unnecessary or unwanted interventions in the hospital when there is no clinical reason to transfer a mom who might be early or post-dates. Many of these women end up having a C-section for no reason other than gestational age because it's outside the receiving hospital or provider's comfort zone. Many professional midwives and doulas have no clinical rights at the hospital when the birthing person would like their assistance at the hospital. Without evidence showing great percentages of birthing persons and babies being put at risk, it is uncertain what the risk is.
- RAC member indicated there is a difference between an induction at 36 weeks and physiologic labor at 36 weeks. RAC member further noted that there may be inaccuracies with dates from the Naegele's Estimated Date of Delivery (EDD) and the early ultrasound EDD, making it possible that the gestation is post 37 weeks. Additionally, a baby at 36 weeks, 3 days that is palpated small for gestational age would be treated differently than a baby that felt like a normal size.
- RAC member via Chat agreed that early babies go into labor naturally versus those being induced.
- RAC member via Chat suggested when voting to separate out 36 weeks+ and then greater than 42 weeks 0 days which aligns with the CABC. The RAC member via Chat further stated, "my personal comfort with 42+1 is less than the 36-37 weeks."
- RAC member stated via Chat further restrictions on gestational age not based on clinical backing, which borders on violating bodily integrity.
- RAC member indicated via Chat that the birth certificate data should be able to tell what the rate of neonatal transfer is for each gestational age. Comparing the rates of transfer by gestational age may be helpful to better understand absolute and relative risk by gestational age.
- RAC member via Chat indicated that midwives working in birth centers usually do not perform artificial rupture of membranes (AROM), especially within 36 weeks gestation. RAC member further indicated by Chat that AROM at term does occasionally happen, but rarely with early babies.
- RAC member stated that the proposed rule fails to account for the individual clinical profile of the patient and how potential risks playing out for the individual patient. It was further stated that birthing persons, especially historically marginalized communities, are making an informed choice and choosing an out-of-hospital birth and these choices are being taken away.
- RAC member via Chat indicated that cord prolapse is more common before 37 weeks with ROM early in labor but can be promptly diagnosed and then transferred to the hospital as it is an absolute risk factor. RAC member further stated via Chat that all birth centers have policies around increased fetal monitoring for post-term pregnancies.

- D. Selover thanked RAC members for the feedback received and noted that the issue of 'primarily and secondarily' has been discussed previously and the Division will need to seek guidance from the Department of Justice. It was further noted that the Division is balancing not just values and autonomy but patient/client safety in a birthing center as well. Furthermore, the Health Evidence Review Commission (HERC) based their decisions on patient safety as well. The proposed rules are not about taking away choice or opportunities. The proposal is based on more than just Oregon data; it's based on studies that are high quality, objective and reliable. Risks and benefits are evaluated considering the whole person, but certain situations may indicate that a transfer is indicated for safety.
- RAC member via Chat indicated that studies are frequently not done in a community setting and therefore are not a reflection of what birthing centers do and which is often quite different. RAC member further expressed appreciation for the Health Authority's desire to keep safety central and reminded those present that risks do not exist in a vacuum.
- RAC member via Chat agreed that safety is central, but that we need to remember that there are birthing people that will not access hospital-based care and if a midwife cannot legally attend their birth, they will have an unattended birth, especially if the hospital does not support their choice around things such as post-dates, breech, or twin delivery.
- RAC members agreed with above statement via Chat.

The following polls were launched:

<u>POLL: Retain "gestational age less than 37 weeks" as a mandatory transfer criterion. Results:</u>

- 0% - I can say an enthusiastic yes to the recommendation (or action).
- 20% - 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.
- 10% - 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.
- 70% - 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 "<u>gestational age greater than 41 weeks, 6 days unless client is already in active labor" as a mandatory transfer criterion. Results:</u>

- 15% - 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.
- 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.
- 38% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

Multiples

Discussion ensued on the "Multiples" risk factor and the requirements from Board of DEM, the HERC and CABC were identified. Discussion:

- RAC member noted that there is not much debate about triplets in the community birth settings. RAC member stated that twin births are complex and acknowledged that there is a significantly higher risk, especially for the second twin, regardless of the setting. It was noted that having multiples is not a disease of pregnancy or something going wrong. It is one of the normal human variations of the way that pregnancy and birth happen. It is important to the Oregon Midwifery Counsel that people who are pregnant with twins have the right and ability to be able to choose physiologic birth in a community setting, especially since it is very challenging to impossible to select a vaginal birth, let alone a physiologic vaginal birth, with twins in a hospital setting. It was further stated that public safety can't just be broken down to a discussion of risk; public safety is more broad. Of particular concern is when birth centers cannot attend twin births and home birth midwives can. This means that a small population of people who choose a community birth setting to deliver twins knowing the risks, are displaced to the home setting which isn't necessarily the best option, especially if they live further from a hospital. A birth center may be the safest and best option for them. RAC member supports patient safety versus being restricted to home birth only. The same is true for breeches and VBACs.
- RAC members via Chat agreed with comment above.
- RAC member stated that if a birthing person makes a choice to deliver twins outside of a hospital, and that person understands the risks, it's wonderful to offer the option of delivering in a birthing center that has close access to a hospital. Birthing centers are in a better position to conduct case review and offer peer support. It's unclear why twin delivery is offered in the home setting and not at a birthing center. Lastly, it was stated that because the risk with twins is so nuanced, it is recommended that twin delivery be moved to the consultation criteria versus an absolute risk factor.
- RAC member concurred that twins should move to consultation.
- RAC members via Chat concurred with recommendation to move to consultation.
- RAC member via Chat stated just because someone is giving birth to twins doesn't mean that anything is going wrong, but that this is normal human variation. People deserve to be able to make the choice to have birth in a community setting. It is known that black and brown birthing people have increased risk of infant and maternal mortality in the hospital setting and that options for birthing people to have a vaginal or physiological birth of twins at the hospital is sometimes not even available at all. All birthing people, but especially people of color, should be able to have the option to choose out of hospital birth and having twins as a consultation criterion is reasonable.
- RAC member via Chat agreed with comment above.
- RAC member remarked that it is difficult trying to explain to birthing families that a provider can assist with twin deliveries in a home but not in a birthing center. Home birth clients have to be referred to other midwives because of how busy the birthing center is. It was noted in Southern Oregon many clients drive almost four hours to birth at the birth center, so to deliver at home and be far away from a hospital is unsafe.
- RAC member stated that while they appreciate the goal and purpose of these rules is not to take away access or choice, the state is hearing from RAC members whether the proposed amendments take away the option to give birth in a birth center. RAC member stated that

everyone would agree that there are times when clients should be advised, informed and even recommended to pursue a specific course of care, but under these laws, it is the client that gets to weigh the risks, choose to integrate those risks into their own values and needs, and make the decision. RAC member opined that women are facing forced surgery in the hospital, or delivery with assistance from somebody without physiological birth skills. It was further stated that injury happens when birthing persons are denied access to providers who are able to make the decision together with a birthing person on a case-by-case basis about whether and how they want to proceed. Journal article, "Maternal deaths after elective cesarean section for breech presentation in the Netherlands" referred to and can be found at: https://pubmed.ncbi.nlm.nih.gov/17364290/

- Several RAC members via Chat agreed with preceding comments.
- RAC member via Chat indicated that many birth center providers disagree with the CABC indicator, and it will likely be challenged in the coming year. Another RAC member stated via Chat that they hope the CABC makes the decision to change.
- RAC member shared their experience of home birth twins and noted they have not seen the degree of preventive care and support needed and received from midwives being offered by hospital-based clinicians.
- RAC member stated it's important that choice is placed back in the hands of birthers. They further stated that black and brown birthers in Oregon are afraid to deliver twins in hospitals. It's too often that the right to deliver out-of-hospital is taken away.

POLL: Retain "Multiple gestation (two or more)" as a mandatory transfer criterion. Results:

- 0% - 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.
- 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.
- 42% - 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 answering poll and asked since there is acknowledgement that there are increased risks with twins and concerns noted that transfer to a higher level of care could be far away, what other conditions could be considered knowing that you are a taking a higher risk? Discussion:

- RAC member indicated that delivery of twins may involve more equipment and more providers and resuscitation capability, including two places to receive the babies that are fully prepared for the possibility that one or more babies may need to be resuscitated. Access to equipment and access to providers is a reason to allow delivery in a birthing center. Many birthing centers are located near hospitals. There needs to be smooth integration in the event of transfer. More attention needs to be placed on ensuring that EMS providers responding to transfer are trained and equipped to handle the transfer.
- RAC member noted that each of the risks discussed are quite different. Sometimes in the HERC guidance there is an exclusion for a community birth that has a very modest increased risk and then there are a few exclusions where the relative risk is higher. The relative risk of the death of a baby in an out-of-hospital breech or twin is 8 to 12 times higher

than for a head-down baby or for singleton babies but that doesn't mean that birth should not occur in a birthing center. It was noted that this doesn't change a person's choice to give birth out of hospital and can make it less safe because this small population of people who choose a community birth, knowing the risks, will do so potentially further from the hospital or potentially with a less trained provider or with no provider. RAC member further remarked that thought needs to be given to supporting the safety of these families, such as adding an additional midwife to the team, much more attention placed on prevention and treatment of post-partum hemorrhage, significant informed choice discussion about risks so that people choosing this option really understand the risk that they're taking. (Reference to an informed choice template for twins was made and will be shared with RAC.) RAC member additionally stated that it's also important to know what kinds of twins there are and get adequate imaging to know different variations in placenta and amniotic sacs because there are really different levels of risks with twin births as well. The two topics of breeches and twins is not about whether they carry greater risk or not. The discussion should not be about whether something has inherently more risk therefore you can't do it because it won't work for the safety of birthing people in Oregon. D. Selover asked where would draw the line when dealing with a home-based birth and not feeling safe? RAC member responded that they do not attend home twin births and most midwives in Oregon would not. There are a small number of practices who have taken special care to have greater training and have more experience. Mono-mono twins would not be a good idea. Certain position combinations would be much higher risk for babies to be born in a community setting.

- RAC member noted that most of the experienced midwives who have the knowledge base to attend twin births are no longer doing them and some of the less experienced midwives are perhaps signing up for that experience for the novelty of it or zest to serve people based on their choice. Allowing twin births in a birth center that meet certain criteria, such as being close to a hospital and having proper staffing and equipment would be a safer setting than a remote home birth.
- RAC member via Chat stated that this sound like an access issue to vaginal delivery of twins. This restriction will just increase cesarean and they don't think that restricting access to midwife/birth center community is needed, rather more access of vaginal birth of multiples is needed. The same is true with VBAC. There needs to be more training across all provider types for those choices.
- RAC member stated via Chat agreement restricting access to care with physiological birth is not only a breach in the statute that was stated previously around client rights to make their own choices but is also a breach in the birthing persons human rights as well. Pushing birthing people into restricted choices doesn't increase good outcomes it just makes it harder for them to access safe choices which include the expertise of a midwife who is an expert in physiological birth as well as their access to hospitals. It's a human rights violation. RAC member via Chat agreed with this comment.
- RAC member via Chat stated agreement that the state needs to demand integration not restrict pregnant persons. RAC members via Chat agreed.
- RAC member remarked that there are a lot of nurse midwives, naturopathic physicians, and licensed midwives that have the skills to perform some of these deliveries. While birth centers that are accredited by the CABC cannot perform these deliveries, there are birth centers who are not accredited that could. It was stated that 'we' don't want to be taking care of births that have additional risk either, however birthing persons are making that choice

considering the risks and weighing the priority of keeping the birthing person as safe as possible.

- RAC member stated appreciation for conversation and that many providers may choose not to offer certain services. The discussion is about whether the state should have a unilateral rule that nobody may offer these services. Current rules do not allow licensed birthing centers to perform twin deliveries or breech deliveries. Maternal health care has changed in Oregon and there has been an increase in unassisted births resulting from a constricting choice in hospitals. Some midwives take it upon themselves to develop and maintain the necessary skills for twin and breech deliveries and some haven't. Just as there are a few doctors who have taken it upon themselves to learn and maintain those skills in the hospital setting, and many have not. Just because some providers may not offer this service doesn't mean it shouldn't be offered to anyone.
- RAC member commented in response to earlier question about what other conditions can be considered for allowing twin births, and that an ultrasound to determine what types of twins is important to determine if delivery would be safe to attempt out-of-hospital. Mono-mono is the riskiest type and is not allowed under the DEM Board rules. Detailed informed consent, making a detailed transfer plan, and making sure the patient understands what things to watch for during the labor process and know what their comfort level is in terms of when to transport if certain things develop. Closer to term, looking at presentation and whether the first baby is cephalic or breech or transverse which affects safety. During labor, ensuring multiple midwives are present and ensuring surveillance and monitoring for any signs of distress. This should require a consult with a provider to make sure that they are also counseling the birthing person on what their risks and concerns are and guide them through what it would be like to deliver in the hospital.
- RAC member noted that in Southern Oregon there is only one doctor in the region that will consider twin physiological birth in a hospital which is rare, making it more likely that anyone with twins will need a C-section in hospital. It was noted that it does not make sense to allow twin births in a home and not in a birthing center.
- RAC member via Chat noted that naturopathic midwives do peer review prenatally and again after delivery for all twin and breech deliveries.
- RAC member via Chat noted that the Oregon State Board of Nursing makes the distinction that nurses should only consider performing any activity, intervention, or role to acceptable and prevailing standards of safe care. Twin delivery would not be considered the prevailing standard. Another RAC member asked why twin delivery wouldn't be the prevailing standard of care? RAC member responded that it is based on the definition of prevailing standard of care, which would be what the majority of practice would do; textbook recommendation; what other level of skilled providers would perform and based on conversations, physiological twin births is controversial. A follow-up question was asked whether twin deliveries by a nurse midwife in a birthing center would be prevailing standard of care? RAC member responded from their perspective if they were asked to consult on a complaint, the nurse midwife would be found in violation of the Nurse Practice Act.

Dana thanked RAC members for comments.

Non-cephalic fetal presentation

Discussion ensued on the "non-cephalic fetal presentation" risk factor and the requirements from Board of DEM, the HERC and CABC were identified. Discussion:

- RAC member noted that the conversation is similar to twins acknowledging an elevated risk that requires special skill and consideration and requires in-depth informed choice with families. It was noted that there is even less access to vaginal breech birth in the hospital in Oregon than there is vaginal twin birth. There are currently no hospitals openly offering vaginal breech birth and when it is not available in the community setting, it puts more strain on birthing persons faced with only the choice of a cesarean birth which is not ethical or evidenced-based practice. It was further noted that breech and non-cephalic presentation should be separate criteria because there are a number of non-cephalic presentations that simply do not work, such as transverse. No one would advocate to provide a transverse delivery at a birth center or home. It was further stated that there is a significant risk for breech birth across the U.S. and Oregon because providers lack appropriate training and experience due to the fact that there is limited access to vaginal breech. It is imperative that all birth providers in all settings are trained and equipped to handle breech. When there is no space for people to gain experience and practice skills, then no one has anything but theoretical preparation for the surprise breech births that do happen in all settings.
- RAC member concurred that vaginal breech delivery mirrors the twin discussion with an increased risk, but the risk is not so significant that it should be excluded from a birthing person's choice. As indicated, there is no access to vaginal breech delivery in the hospital which means a birthing person's choice for a vaginal breech delivery will require an unattended, or home birth. Allowing vaginal breech in a birthing center would allow more structure and might be closer to a hospital if needed. It was noted that breech babies are not all alike, and some may be safer to delivery than others, and the Board of DEM rules should be considered such as lack of adequate progress in second stage. Detailed informed consent along with educating patients about the increased risks and informing them that cesarean is an option is needed. RAC member recommended that breech therefore be a consultation criterion.
- RAC member stated that what differs between the twin and breech discussion is the unique skills necessary for safe delivery of different non-cephalic presentations and breech positions. It was indicated that there is a "massive deskilling in obstetrics around breech delivery that is affecting women's options." RAC member stated the RAC needs to consider whether providers who have the skills to support these birthing persons may be allowed in a birth center. Personal story was shared about a pregnant person who experienced traumatic racism in hospital in another state after the midwife had to transfer client because of breech presentation and upon arrival, hospital refused to perform delivery because the patient did not want to have a cesarean. The patient was transferred to another hospital that also insisted on a cesarean, but the infant was born breech with no assistance from hospital staff. The patient was disparaged for breech delivery and reported to child welfare. Question was posed to RAC whether the rules are making birthing persons safer when the birthing person is told they are not allowed to access midwife care that a midwife, in their clinical discretion, is willing to offer in out-of-hospital spaces?
- RAC members via Chat agreed that breech and non-cephalic presentation should be separated, and that breech should be a consultation criterion.
- RAC member remarked that birthing people historically have had a lack of choice around what happens to their womb, especially birthing people of color and when we choose to restrict access to experts who have the level of skill necessary to facilitate a breech birth, we are perpetuating a system that takes away a birthing person's right to choose. More

midwives of color are needed to address the disparities in the community. If there is no access to practice in settings where people work, then the training is theoretical, and expertise in the community remains limited.

D. Selover thanked RAC members for information shared and asked whether there are any specific conditions, similar to twins, that could be considered, such as distance to hospital, system integration, agreements, etc.?

- RAC member shared that Oregon Midwifery Council's informed choice template for breeches and twins outlines those things in detail and they will send it in.
- RAC member shared that when they used to do breech, they only served pregnant people with a prior vaginal birth and would consider parity, and previous birth experience such as length of second stage. The type of breech is important as well as the size of the baby. In-depth informed consent is needed and should include the birthing person's partner. Setting expectations is important.
- RAC member via Chat indicated that if breech is allowed, they would suggest adding previous vaginal births to criteria which would reduce risk.
- RAC member via Chat indicated that conditions would be the same as for twins including extra providers and equipment.
- RAC member stated via Chat that it is not acceptable that a provider is not trained on delivering breech, it should be common, and should not be illegal to train individuals on how perform life-saving techniques. It was noted that the previous story shared is not uncommon for black and brown bodies in Oregon.
- RAC member stated that based on information provided today these categories should be allowed in a birthing center with special requirements in terms of informed consent and client education about risks. This is especially important because of inadequate and disproportionate effects on birthing people of color. These options should be available to birthing persons because they don't have the option in a hospital. The risk to birthing persons for repeat cesareans significant and a significant factor in the maternal morbidity rate in the US.
- RAC member commented that in considering the rules, the RAC needs to consider what are the other purposes for a birthing center beside low risk births. It was stated that one important purpose is the protection of the safety of birthing people and protecting rights is protecting safety. It was stated that as the risk of giving birth in the hospital setting goes up, birthing persons are willing to accept a higher level of risk outside of the hospital. It was further stated that hospital spaces and obstetric spaces have increasingly become surgical delivery spaces, and therefore birthing centers have become an important space for vaginal birth. RAC members via Chat concurred.

<u>POLL: Retain "breech or non-cephalic presentation" as a mandatory transfer criterion. Results:</u>

- 0% - I can say an enthusiastic yes to the recommendation (or action).
- 27% - 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.
- 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.

- 55% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

Wrap-Up

D. Selover thanked RAC members for their participation. RAC members were encouraged to submit additional information to M. Bernal via email.

It was noted that the Division will be planning the following:

- VBAC discussion;
- Community meeting.

RAC adjourned at: 3:45 p.m.