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Birthing Center Rule Advisory Committee
August 24, 2021
9:00 a.m. via Zoom

RAC MEMBER ATTENDEES	
Desiree LeFave	Bella Vie Gentle Birth
Hermine Hayes-Klein	Oregon Association of Birth Centers
Karen DeWitt	Oregon Association of Naturopathic Physicians
Kaylyn Anderson	Consumer
Lynette Pettibone	American Association of Birth Centers
Margy Porter	Bella Vie Gentle Birth Center
Michelle Zimmerman-Pike	American College of Nurse Midwives
Silke Ackerson	Oregon Midwifery Council
Willa Woodard	Rogue Birth Center
OTHER INTERESTED PARTY ATTENDEES	
Kori Pienovie	Womens Healthcare Associates, Midwifery Birth Center
Rebeckah Orton	Astoria Birth Center
Stephanie Bates	Public Citizen
Sharron Fuchs	Public Citizen
OHA Staff	
Anna Davis	PHD-Health Facility Licensing & Certification
Dana Selover	PHD-Health Care Regulation & Quality Improvement
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. Participants were asked to enter their name, organization and whether they are a RAC member or member of public into the Chat.

Review of July 21 Meeting Notes

D. Selover asked RAC members if there was any feedback on the notes. Clarification was provided to RAC member who questioned element of the meeting notes that specified "for current discussion purposes only." It was noted that several additional steps occur prior to final proposed rulemaking with the Secretary of State including review by the Department of Justice. As a reminder, the Birthing Center RAC is advisory only. The Oregon Health Authority will consider the RAC's input, however, the Authority retains the final decision on final rule text.

Proposed OAR 333-077-0125 – Risk Status Assessment and Consultation Requirements

D. Selover opened discussion on the proposed changes to OAR 333-077-0125 based on discussions from the July 21 RAC meeting. As requested, the rule was revised to incorporate the definition of Oregon licensed health provider based on the Board of Direct Entry Midwifery administrative rules. It was noted that sections (1) and (5) would be discussed together.

> (1) As used in this rule, "provider of maternity care" 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.
> (5) A clinical provider at the birthing center shall consult with a provider of maternity care if the client or fetus meet any of the consultation criteria specified in Table III. The consulting provider of maternity care must be:
> (a) Credentialed to admit and manage responsibilities in a hospital; or
> (b) A specialty provider (for example, maternal-fetal medicine, hepatologist, psychiatrist); and
> (c) Experienced and knowledgeable about the indication(s) for consult.

As the rule is currently proposed, the 'provider of maternity care' is the person that a clinical provider at the Birthing Center would consult with if the client or fetus meet the consultation criteria specified in the proposed Table III. The Authority asked the RAC members to describe how 'providers of maternity care' without specialized credentials may offer specialty consultation?

Discussion on sections (1) and (5):

- RAC member stated that while the minutes correctly described the birth centers position on consultation language, the proposed language in section (5) does not. Question was posed why the Authority did not adopt DEM language directly. The Authority responded that the Board of DEM language was used as a foundation. These rules are for birthing centers (facility) not individual providers.
- Concern was noted that it is unclear where consultation with another out-of-hospital (OOH) provider, such as a licensed DEM, is allowed in the rule based on the examples provided under "specialty provider." It was suggested that the Board of DEM definition for consultation be incorporated – "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."
- RAC member concurred that for purposes of consultation it is important to include language that ensures a provider has direct experience handling complications of the risk(s) present given the number of different risks and remarked that section (5) is unwieldy, and specificity may be problematic.
- Staff noted that the Authority will consider adding a licensed DEM to the examples or possibly list as a separate provider. It was noted that it's important to make sure that both OOH providers and hospital-based providers are included. RAC members commented via chat that DEM's should be listed as a specialty provider. It was further noted via chat, that

there are risk factors that may require a specific type of consultant for purposes of licensed DEMs (example Direct Coomb's positive requires a consultation with a pediatric care provider.)

- Concern was expressed about use of the term "provider of maternity care" when a consultant may be a pediatrician or pediatric subspecialist
- RAC member noted that the scope of practice of the provider must also be considered for purposes of consultation.
- It was noted that for purposes of a survey and determining compliance with the requirement that an individual had direct experience with specific risks, the Authority would expect the facility to ensure that the education and training of the provider would be documented in the birthing center records, and that the education and training are specific to the condition/diagnosis/risk being assessed. Staff provided additional information on enforcement and applying rules.
- Question was posed regarding how do you hold a birthing center responsible for the consultation requirement versus an individual? Staff noted that licensed facilities must make sure that policies and procedures are adopted and implemented to ensure that providers/staff are doing what is required in rule. Allegations specific to a provider's scope or license are referred to the appropriate licensing board.

Section (2) was opened for discussion:

> (2) A clinical provider at the 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.

Discussion:

- RAC members had no comment.

Section (3) was opened for discussion. Staff recommended that the term "performed" be changed to "completed" based on the nature of the date language. In addition, feedback was requested from RAC members on whether the 21 days should be changed if a person does not begin receiving care until a later stage of pregnancy.

> (3) An initial risk assessment shall be performed within 21 calendar days of the initial prenatal care visit and updated throughout the pregnancy, labor, and delivery.

Discussion:

- RAC member noted that it is frequently difficult to obtain records from other providers in a timely manner which is why 21 days was requested by RAC. Clients who transfer to a birthing center late in a pregnancy are asked to bring records with them.
- No additional comments or suggestions were made by RAC members.

Section (4) was opened for discussion.

> (4) 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 based on the

performance of the initial risk assessment, periodic risk assessments or a consultation conducted in accordance with section (5) of this rule.

Discussion:

- RAC member via chat asked whether a certified nurse midwife could repair 3rd degree lacerations? If a CNM can repair, it would not be considered a consult or transfer because it is within their scope of practice. It was further stated that a facility would need to ensure that they are equipped to complete a procedure that is within the provider's scope.
- Staff noted that consideration must be given to not only the scope of practice but the facility setting and whether the necessary equipment is available, and the physical environment meets appropriate standards.
- RAC member stressed the importance of understanding the different levels of providers that work for birthing centers and the importance of having rules that do not impede provider scope. A CNM can perform 3rd degree laceration repair in a hospital or birth center.

Section (6) was opened for discussion.

(6) The consulting provider of maternity care may not be an employee or credentialed provider of the birthing center.

Discussion:

- RAC member expressed concern that there will be unintended consequences. Example provided of the medical director being employed by the birthing center and a physician call group that is theoretically employed by the same entity.
- Staff noted that there may be some risk factors that could be problematic for consulting only in-house. Staff acknowledged that credentialed providers may need to be considered further and asked RAC members whether anyone had recommended language to address issue of credentialed providers that might be appropriate.
- It was suggested that a credentialed provider with hospital privileges may be a way to address. RAC member commented that several birth centers employ nurse midwives that have hospital privileges and if something is restricted in the birth center but is within the providers' scope of practice in the hospital, it doesn't make sense that they would consult with someone outside the practice. It's more important that they are consulting with the appropriate level of provider not whether they are an employ of the birth center. It was suggested whether section (6) is even necessary.
- Staff noted concern about at what point does the consultation and decision about transferring to a higher level become a problem. The consultation is mostly for a decision to transfer to a higher level of care for the birth and possibly some prenatal care. Staff will consider further.
- Staff from the Health Licensing Office will share Board of DEM rule language for consideration.

Sections (7) and (8) were opened for discussion.

(7) 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 findings and recommendations from the consultant.

(8) The clinical provider at the birthing center shall document the following information within seven calendar days of the consultation:
(a) Who participated in the consultation;
(b) Information shared with the consulting provider;
(c) Findings and recommendations from the consulting provider;
(d) Discussions with the client during or after the consultation about the findings and recommendations;
(e) Decisions made by the client for continued care; and
(f) Plan of care.

Discussion:

- RAC member expressed concern about the term "findings and recommendations from the consultant" in subsections (8)(c) and (d). It was stated that the purpose for the consultation is to gather information and there may not be any finding. A finding also implies that an examination is performed of a patient and some consultations may not occur with a client. It was stated that documentation of "findings or recommendations" creates a liability risk for both the provider making a recommendation and the provider receiving the information. It was further stated that recommendations are an opinion and therefore the benefit is questionable whereas the risks could be significant to the facility.
- Staff noted that for purposes of OARs, the Authority must consider what is in the best interest for the client. The point of a consultation is to ensure that the client has as much information as possible to make an informed decision so it would seem odd that a consultation would occur without the client.
- Staff noted that for purposes of a survey, the agency is not second guessing the outcome of the decision made, rather that there was meaningful input from the person consulted. A client may want to make different decision based on the information provided from the consultant. The information shared and the input from the consultant needs to be documented so that the surveyor can confirm that the consultation occurred. Further, surveys use the term “findings” not in a clinical sense, but in terms of documenting what was observed on survey.
- Staff from the Health Licensing Office noted that the Board of DEM also discussed the importance of documentation, the importance of the information provided by the consulting provider, and the decision made. The following Board of DEM rule language was shared:

  332-025-0021 (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.

332-025-0110 (2)(h) Records mean written or electronic documentation, including but not limited to documentation of all consultations pursuant to OAR 332-025-0021 (14) through (22) and recommendations regarding indications for consultation from an Oregon licensed health care provider as defined under OAR 332-025-0021(21), or any other provider specifically identified in OAR 332-025-0021;

- RAC member expressed that the Oregon Midwifery Council would be uncomfortable with removing documentation of recommendations. It was acknowledged that it's possible that no recommendations are made and that could be reflected in the documentation. There are a number of complaints and peer reviews where the recommendation from the consulting provider was not communicated with the client and the client in retrospect felt they didn't have the information needed to make an informed decision about a risk factor.
- RAC member expressed that meaningful information is desired and suggested using the term 'or' versus 'and' and replace 'findings and recommendations' with 'information.' It was stated that some OB consultant employers do not allow the birthing center to write that the OB made a recommendation. It was stated that the current language would be problematic.
- RAC member stated that some consultation occurs over the phone and without having met the client, the consultant cannot make an "official" recommendation. Changing to 'information' or replacing the term 'and' with 'or' may be helpful.
- Staff noted that depending on the risk factor there may be some consultations that require additional follow-up or more rigor that doesn't involve just a phone conversation.
- For the record comments via chat included:
    - Consulting providers do not know the birthing center rules; and
    - Consulting providers do not believe that any OOH birth is safe.

Section (9) was opened for discussion.

(9) Notwithstanding section (4) of this rule, if a risk assessment or consultation determines that an OOH birth is no longer indicated, a birthing center may continue to provide prenatal care to a client if:
(a) The client is reasonably informed of known material risks and provides consent to continue to receive prenatal care;
(b) The client acknowledges that the birth will not take place at the birthing center and that a hospital birth has been recommended;
(c) Documentation of subsections (8)(a) through (f) of this rule is documented in the client's medical record.

Discussion:

- RAC member stated that the Oregon Association of Birth Centers has a problem with any rule language that could be interpreted as "giving power to the non-birth center provider with whom the birth center is seeking the consultation to make a determination that an OOH birth is no longer appropriate if the client remains within scope." It was requested that the rules be clear that the consultant does not get to determine whether an OOH birth is no longer indicated. The client and the birth center provider through a shared decision-making process using the information shared should decide what is the safest course of care. It was further stated that language about continuing to receive prenatal care after 'risking-out' should be moved to the general sections of the rule.
- Staff noted that a risk assessment may reveal a finding that is found in the risk factor tables and therefore the birth would not be able to occur at a birthing center. Staff will consider

placement of the rule language in consultation with Department of Justice and consideration of statutory language about low risk.

- RAC member stated that the RAC is revisiting the regulations that identify who is low risk by setting the "scope of services" for birth centers through the risk factor tables. OAR 332-025 set the scope of services for Licensed DEM's.
- RAC member stated that all OOH birth providers in Oregon attend low risk births which is within their scope. RAC member further stated there are two outcomes for a consultation under DEM rules: 1) arrange to transfer care; or 2) seek informed consent to continue care after communicating recommendations and making a plan of care. It was recommended that this be allowed under the birthing center consultation rule. It was reiterated and information paraphrased from the chat that many consultants may say that there is no increased risk to the client, but they do not recommend an OOH birth.
    - RAC member via chat stated that a hospital-based provider may say there is not an increased risk for a patient when OOH birth provider will identify that there is.
- For the record comments via chat:
    - Licensed DEM statute scope of practice – ORS 687.405 As used in ORS 687.405 to 687.495, “direct entry midwifery” means providing the following services for compensation: (1) Supervision of the conduct of labor and childbirth; (2) Providing advice to a parent as to the progress of childbirth; (3) Rendering prenatal, intrapartum and postpartum care; and (4) Making newborn assessments.
    - The LDM scope of practice in statute is not tied to or related to "low risk."
    - Possible solution is while the OOH birth providers are required to consult with in-hospital providers, that in-hospital providers should be required to document and submit their recommendations and rationales as well.
- RAC member stated that "low risk" is related to the birth center statute and each of the OOH provider types (ND, CNM, and LDM) have their own statues and rules which are each distinct and have their own scope of practice. Low risk defined in the HERC guidance is only one way to relate to risk. The OOH provider scope of practice in relation to risk is a lot broader.
- Staff indicated that information will be taken under consideration and additional changes to the rule will be considered.

RAC adjourned at: 11:48 a.m.