PUBLIC HEALTH DIVISION
Office of Health Care Regulation and Quality Improvement
Kate Brown, Governor

Oregon Health Authority

800 NE Oregon Street, Suite 465
Portland, OR 97232
Voice: (971) 673-0540
FAX: (971) 673-0556
TTY: 711

**Birthing Center Rule Advisory Committee**
**February 15, 2022**
**1:00 p.m. via Zoom**

| RAC MEMBER ATTENDEES | |
|---|---|
| Desiree LeFave | Bella Vie Gentle Birth Center (Administrative) |
| Hermine Hayes-Klein | Oregon Association of Birth Centers |
| Jennifer Gallardo | Andaluz Waterbirth Center |
| Karen DeWitt | Oregon Association of Naturopathic Physicians |
| Kaylyn Anderson | Consumer |
| Laura Erickson | Alma Midwifery Services |
| Lynette Pettibone | American Association of Birth Centers |
| Margy Porter | Bella Vie Gentle Birth Center (Clinical) |
| Michelle Zimmerman-Pike | Oregon Affiliate of the American College of Nurse Midwives |
| Sarah Wickenhagen | Oregon State Board of Nursing |
| Silke Ackerson | Oregon Midwifery Council |
| Stefanie Rogers | Providence |
| Willa Woodard Ervin | Rogue Birth Center |
| **OTHER INTERESTED PARTY ATTENDEES** | |
| Christina Clay | Care Oregon/Alma Midwifery |
| Debbie Cowart | Growing Family Birth Center |
| Ray Gambrill | AllCare Health |
| Sharron Fuchs | Public |
| Stefanie Bates | Public |
| Tracy Lawson Allen | Midwife; Administrator OABC; Public |
| Wendy Smith | Legacy Emanual; Board of DEM |
| **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 |
| Mellony Bernal | PHD-Health Care Regulation & Quality Improvement |

| 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. |

**January 10, 2022 Meeting Notes**

RAC members were asked via e-mail to submit any comments on proposed changes to the January 10 meeting notes by e-mail.

**Overview of Agenda**

Dana Selover reviewed agenda. The goal is to get through Table II and discuss framing future conversations to wrap up Table I. Additionally, it was noted that there remain a few outstanding action items from the OAR rule text that need to be reviewed (e.g., dietary services.)

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

D. Selover noted that based on feedback from the January RAC meeting, Table II was revised removing references to "consideration." It was further clarified that changes to the risk criteria based on the January discussion were not changed yet, only the title to the table. Therefore, for voting purposes, Table II consists of risk factors that would require transfer to a hospital.

**Laceration requiring hospital repair:**
**- Cervical or 3rd or 4th degree trauma**
**- Extensive vaginal**

RAC member indicated that these risk criteria are an important example where different provider types working in a birthing center have different scopes of practice. While this may be an appropriate criterion for a Licensed Direct Entry midwife (LDM), a Certified Nurse Midwife (CNM) or Naturopathic Physician (ND) may have the experience and scope to perform laceration repairs. Additionally, the equipment needed to do these repairs could be available in a birthing center. Retaining these criteria in the standards should reflect information about the provider and scope.

- RAC members commented on the availability of providers to come to a home or birthing center to repair a 3rd degree laceration.
- RAC member noted that "extensive vaginal repair" is too broad, for example there may be an extensive, 2nd degree repair that would be within provider scope.
- Several RAC members via chat concurred with comments above.
- D. Selover summarized that this is more an issue of scope of practice and capability versus equipment requirement. It was noted there are likely lighting and sterilization requirements and OHA staff would need to look further into equipment requirements. Examples of equipment from RAC member included lighting, firm surface and possibly retractors.

D. Selover noted that since there is nothing in the tables that refer to scope of practice what language should be considered for this risk criteria? The following suggestions were noted via Chat:

- Laceration requiring repair that exceeds scope and experience of provider
- Laceration repair at your level of knowledge, skills and ability
- Laceration requiring repair that exceeds available provider skill level

D. Selover thanked RAC members for feedback and noted that the program will need to seek advice from legal counsel on the proposed suggested language.

No poll was administered.

**Retained Placenta > 60 minutes**

The current proposed language is based on 2015 HERC. RAC member asked other members whether anyone had any issues with the current Birthing Center table requirement. The following differences were identified between HERC, current PHD OAR, and current DEM OAR.

| **2020 HERC** | **OAR 333-076<br>Current Table III** | **DEM OAR<br>332-025-0021 (11)(v)** |
|---|---|---|
| Placental conditions - Retained placenta > 60 minutes | Retained placenta or incomplete placenta, with bleeding; suspected placenta accreta; retained placenta >3 hours | Retained placenta |

D. Selover asked RAC to consider the risks and benefits for each of the different criteria noted above.

- RAC member noted that 60 minutes versus 3 hours may be based on the mother's condition and what may be occurring (e.g., breastfeeding, laceration repair, etc.) A mother may have a retained placenta and still be stable after 60 minutes, thus the value of requiring a transfer right at 60 minutes is unclear. RAC member indicated support of retaining the 3-hour maximum or a time period between 60 minutes to 3 hours if data is available to support.
- RAC member provided some background from the LDM discussion:
  - Provider judgement
  - Accepted definition is 60 minutes however, for purposes of an investigation, the chart would need to clearly document the justification of why a different decision was made
  - Flexibility and provider responsibility for assessment
- RAC members concurred with comments above via Chat.
- D. Selover noted that an investigation in a birthing center setting is different than at professional license level. Actions taken when placenta is retained for greater than 60 minutes, i.e. calling 9-1-1, transport time to hospital, etc. may add additional time.
- RAC member stated via Chat that they concurred with comments from RAC member and provided an example of woman who is not bleeding, is nursing baby, whose vitals remain normal, and then after 45 minutes provider starts to deliver placenta and it is finally expelled after 65 or 70 minutes.
- D. Selover inquired whether the literature, or by experience, indicates a time that a transfer must be taken (no later than?); CABC? Other?
  - RAC member noted that 60 minutes is the evidence, but it does not mean the placenta needs to be out exactly at 60 minutes, rather the provider needs to take action if it is not out at that point.

- Staff indicated that not having a time frame will make it difficult for an investigation. At what point does some action need to take place?
- RAC member suggested that the language be updated to reflect that the placenta does not need to be out at 60 minutes rather a provider action is taking place to get the placenta out.
- RAC member suggested via Chat that the 3-hour time frame is reasonable as a place to draw a hard line.
- RAC member suggested via Chat including language about active management after an hour. Providers all know that transfer is needed for a hemorrhage that is not under control.

- Staff noted for purposes of voting consider that a provider takes action at 60 minutes and the placenta may be expelled after 70 minutes, how may the RAC vote?

<u>POLL: Retain "Retained placenta" as a mandatory transfer criteria. Results:</u>

- 11% - I can say an enthusiastic yes to the recommendation (or action).
- 22% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 33% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 11% - I do not fully agree with the recommendation and need to register concern. However, I will not block the recommendation. More discussion is necessary for full support.
- 33% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

**<u>Temperature ≥ 38.0º C (100.4º F)</u>**

Staff noted that DEM rules are different with respect to temperature as follows:

OAR 332-025-0021(11)(f) – Indication to Transfer Intrapartum

- Two temperatures at 100.4 degrees Fahrenheit or 38 degrees Celsius or greater within one hour; or
- One temperature at 102.2 degrees Fahrenheit or 39 degrees Celsius or greater.

D. Selover noted that 2020 HERC requirements specify: Maternal temperature ≥ 38.0 degrees Celsius in labor/postpartum

RAC member stated that the LDM rule is preferred because there are situations where someone could temporarily have an increased temperature due to other passing issues such as being in the tub too long. D. Selover asked whether that was based on guidance or other literature. RAC member did not recall but indicated part of it is clinical experience. D. Selover further noted that a 'fleeting temperature' is different than actually having an ongoing temperature.

RAC member comments via Chat included:

- Risk factor should include "unresponsive to treatment or unrelated to known causes like cytotec."

- "Pitocin will temporarily elevate maternal temp, so it's common to wait for the dose to wear off and recheck temperature. I meant miso[prostol]."
- "A single elevated temperature of 38 or greater does not meet the definition of a fever.
- "Can we change it to say fever not temperature?"

RAC member indicated that modeling language after the Board of DEM rules would work, one hour is a reasonable amount a time for medications to wear off and get a more accurate reading including considering other factors such as being in a tub.

Additional comments from RAC member via Chat:

- "I have experienced a client with a cytotec fever that lasted 3 hours."
- "Current birth center laws are good. They give you that leeway needed for waterbirth. 101."

RAC member suggested referencing 'unresolved' or 'persistent' but concurred with LDM language.

RAC member indicated that temperature is trying to address infection and as discussed other things may cause an elevated temperature. In any setting, it is not necessarily treated until it reaches the definition of a fever. An isolated temperature at a hospital is not necessarily going to be treated any differently. RAC member indicated the LDM language makes a lot of sense.

D. Selover called for vote as drafted:

<u>POLL: Retain "Temperature ≥ 38º C (100.4º F) as a mandatory transfer criteria. Results:</u>

- 0% - I can say an enthusiastic yes to the recommendation (or action).
- 11% - 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.
- 22% - I do not fully agree with the recommendation and need to register concern. However, I will not block the recommendation. More discussion is necessary for full support.
- 67% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

**<u>Chorioamnionitis or other serious infections including but not limited to:</u>**
**<u>- Cytomegalovirus (CMV)</u>**
**<u>- HIV</u>**
**<u>- Rubella</u>**
**<u>- Toxoplasmosis</u>**

Staff noted that HIV – Known and unknown status was discussed under Table I.
D. Selover noted that HERC guidance under infectious conditions has Chorioamnionitis listed separately as well as Toxoplasmosis.

- RAC member via Chat indicated that chorio should be separately from other infections.

- RAC member concurred with Chat comment and noted that Chorioamnionitis really should be separate from the rest of the listed risk factors and stated no objection to chorioamnionitis. CMV, Rubella and Toxoplasmosis make sense but are prenatal not intra or post-partum and belong in one section. HIV is a totally different topic and also prenatal. A person with well controlled HIV could be a birth center candidate with good PPE.
- D. Selover noted that if the infection is listed in Table I it may not be necessary to list in Table II.
- RAC member agreed that conditions should stay in prenatal except chorio and chorio should be changed to persistent and unresolved signs because sometimes signs of chorio may resolve. Via Chat, this RAC member indicated "Other infections should be dealt with prenatally and need a consult." Further stated, "Suggested language: Persistent unresolved signs of Chorioamnionitis."
- RAC member stated both for discussion and via Chat that CMV, Rubella and Toxoplasmosis would generally not be found intrapartum even in a hospital setting. If someone comes in without labs, they might run a prenatal panel which would have HIV and Rubella but the overwhelming majority of times that is a prenatal issue and is probably not needed on this table.
- RAC members concurred via Chat.

D. Selover called for vote for each risk factor as currently written. For purposes of Chorioamnionitis, it is assumed that this condition has been diagnosed and that language such as persistent or unresolved is not necessary.

POLL: Retain "Chorioamnionitis" as a mandatory transfer criteria. Results:

- 44% - I can say an enthusiastic yes to the recommendation (or action).
- 22% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 22% - 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.
- 11% - I do not fully agree with the recommendation and need to register concern. However, I will not block the recommendation. More discussion is necessary for full support.
- 0% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

POLL: Retain "Rubella" as a mandatory transfer criteria. Results:

- 33% - I can say an enthusiastic yes to the recommendation (or action).
- 11% - 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.
- 33% - I do not fully agree with the recommendation and need to register concern. However, I will not block the recommendation. More discussion is necessary for full support.
- 22% - 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 "Known HIV positive status" as a mandatory transfer criteria. Results:

- 11% - I can say an enthusiastic yes to the recommendation (or action).
- 11% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 11% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 33% - I do not fully agree with the recommendation and need to register concern. However, I will not block the recommendation. More discussion is necessary for full support.
- 33% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

POLL: Retain "Toxoplasmosis " as a mandatory transfer criteria. Results:

- 13% - I can say an enthusiastic yes to the recommendation (or action).
- 13% - 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.
- 50% - I do not fully agree with the recommendation and need to register concern. However, I will not block the recommendation. More discussion is necessary for full support.
- 25% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

POLL: Retain "CMV" as a mandatory transfer criteria. Results:

- 11% - 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.
- 11% - 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.
- 67% - 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.
- 11% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

A RAC member via Chat indicated that the infections voted upon need to be in a prenatal consultation category and RAC members via chat concurred.

**Failure to progress/failure of head to engage in active labor**

RAC member recommended removing the reference to failure of the head to engage as with multiples it is more common for the head not to engage than to engage. Recommended adoption of the LDM rule with failure to progress because they are more specific. "Failure to progress" may be defined in many ways.

- LDM rule states, 'lack of adequate progress in second stage with cephalic presentation, which means no descent after a maximum of three hours of active pushing in cases with complete dilation and ruptured membranes.'

RAC member indicated that this risk factor is more appropriate for specific provider practice standards or rules. Something this vague (failure to progress/failure of head to engage) should not be in a facility type rule. This is subjective and provider judgement and would be difficult to define.

RAC member concurred with previous comments. It can be normal for a multiple to not have head engage and the failure to progress could be a reason to transfer but would be hard to do a chart review and say at what point someone was classified as “failure to progress.” There are more standard definitions in second stage not in first stage and even 'active labor' has changed over time. It may be reasonable to remove entirely.

D. Selover noted that any change to this should be based not only on comments about practice but relevant literature. Taking it out would be in conflict with both HERC and LDM rules.

- RAC member stated that the issue is there is no agreed upon definition of 'failure to progress' and it is an area of active debate in the literature, among professional organizations and is constantly changing. It's important to note that in the LDM rule it only relates to second stage. Birth center rules should have a clear delineation of things that should not occur at a birth center. RAC member noted that even LDM rule has been an issue in terms of investigations. Taking it out of Birthing Center rules does not change the requirement that an LDM must follow LDM rules.
- D. Selover responded that this is an example of where it is being approached from a medical-legal perspective versus risk factor perspective and really good justification to change is needed.
- RAC members via Chat commented:
  - We have enough other rules where we would transfer someone if lack of progress was causing issues.
  - Failure to progress according to whom or which graph?
  - The definition would be so broad
- RAC member indicated that the only way to make clear would be to define active labor and add 'along with non-reassuring heart rate tones' which is already covered and as such would be redundant. She further agreed that it should be removed altogether or possibly align with LDM rules. RAC member commented that in most cases with bad outcomes related to prolonged labor, there are probably other factors going on like chorioamnionitis, un-reassuring heart rate tones, or other clearly defined factors.
- RAC members via Chat commented:
  - Agree that failure to progress is very vague. We have specific policies and procedures related to prolonged early, active, and second stage labor. Mostly related to maternal and fetal stability and maternal consent to continue with labor at the birthing center.
  - If risk factor remains it should be failure to progress in second stage only.
  - Failure to progress is unacceptably vague. This should mirror the LDM rule for consistency and because it defines "lack of adequate progress."

D. Selover called for vote:

POLL: Retain "Failure to progress" as a mandatory transfer criteria. Results:

- 0% - I can say an enthusiastic yes to the recommendation (or action).
- 0% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 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.
- 11% - 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.
- 89% - 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 "Failure of head to engage in active labor" as a mandatory transfer criteria. Results:

- 0% - I can say an enthusiastic yes to the recommendation (or action).
- 0% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 0% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 0% - I do not fully agree with the recommendation and need to register concern. However, I will not block the recommendation. More discussion is necessary for full support.
- 100% - 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 noted that as members vote on different sections, a lot of discussion and inability to reach agreement is because there are different provider scope types that need to be addressed. Rules would be less complicated by just including language that acknowledges 'within provider's defined scope and experience.' It was further noted that there are too many different layers that must be complied with - Birth Center licensing, LDM licensing and OHP licensing. It feels like the BC licensing rules restrict not only LDMs, but CNMs and other people working in birth centers. D. Selover acknowledged and reminded RAC that Birthing Centers are limited in statute to low risk births and provider types are not subject to that same restriction. D. Selover noted that the birthing community could work with the Oregon legislature to change that limitation. The HERC requirements, the provider requirements and the Birthing Center requirements all must abide by their respective statutory authorities.

**Prolapsed umbilical cord**

RAC member commented via Chat, "transport"

D. Selover called for vote:

POLL: Retain "Prolapsed umbilical cord" as mandatory transfer criteria. Results:

- 100% - 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.

- 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.
- 100% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

**Repetitive or persistent fetal heart rate patterns**

RAC member stated that this language is not clear enough and may be in another section which addresses non-reassuring fetal heart rate tones. There are some arrythmias that 'act up' during labor and become more persistent but would not necessitate a transfer. It was suggested that an absolute transfer criteria should reflect "non-reassuring or fetal compromise" and have arrythmias or persistent fetal rate be a consult criteria.

D. Selover noted this is intrapartum condition.

RAC member shared on behalf of another birthing center owner that could not attend the RAC to consider adding reference to unresponsive to treatment.

RAC member via Chat shared that PACs are an example of a persistent abN fetal heart rhythm that does not necessarily require transfer.

D. Selover called for vote:

POLL: Retain "Repetitive or persistent abnormal fetal heart rate pattern" as a mandatory transfer criteria. Results:

- 75% - I can say an enthusiastic yes to the recommendation (or action).
- 13% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 13% - 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.

**Uterine rupture, inversion or prolapse**

RAC member remarked that "prolapse" should be removed entirely or moved to a different section as there are different variants of prolapse, some of which may require physical therapy in the post-partum period. A prolapse could be moved to consult. A uterine rupture or inversion would be a mandatory transfer.

RAC member concurred with comment above and indicated that since rupture and inversion are so different, they should be listed by themselves.

RAC member concurred with separating out.

RAC member remarks via Chat:

- Prolapse under consult or take out
- Prolapse should be under consult not transfer
- Uterus prolapse procidenta is a transfer

D. Selover called for vote:

POLL: Retain "Uterine rupture" as a mandatory transfer criteria. Results:

- 100% - 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.
- 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.

POLL: Retain "Uterine inversion" as a mandatory transfer criteria. Results:

- 78% - 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.
- 22% - 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.

POLL: Retain "Uterine prolapse" as a mandatory transfer criteria. Results:

- 11% - 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.
- 33% - I do not fully agree with the recommendation and need to register concern. However, I will not block the recommendation. More discussion is necessary for full support.
- 56% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

**Thick meconium staining of amniotic fluid**

RAC member noted that data is clear that meconium in absence of fetal distress and other things can be well-managed in the out-of-hospital setting and it should be removed as NRP does not recommend suctioning of the perineum anymore. Meconium by itself should not necessitate a transfer.

RAC members via Chat indicated agreement with comment above.

D. Selover called for vote:

<u>POLL: Retain "Thick meconium staining of amniotic fluid" as a mandatory transfer criteria.</u>
<u>Results:</u>

- 0% - I can say an enthusiastic yes to the recommendation (or action).
- 0% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 0% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 0% - I do not fully agree with the recommendation and need to register concern. However, I will not block the recommendation. More discussion is necessary for full support.
- 100% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

**Planning for Future Meetings**

Given time frame left. D. Selover suggested that the March meeting be changed to complete Table II and bring back some of the remaining rule language, such as dietary services.

- RAC member agreed with plan to get through rest of risk factors in Table II and circle back to the Table I deferred risk factors. RAC member asked whether additional time would be granted to submit additional material for the topics to be discussed. RAC member further suggested that in order for the meetings to be meaningful and robust, it would be important for people who believe these risk factors should be included in the new tables to be present to be able to articulate concerns that are driving their inclusion. It was further asked that OHA include persons who can speak to the inclusion of these risk factors on the Table to articulate concerns and allow persons to respond to those concerns as well as have experts on the data present who can speak to what the safest rule is going to be.
- D. Selover indicated this would be discussed further at the March meeting and yes, the deadline to submit material will be extended and information will be shared by e-mail.

**Wrap Up**

RAC member shared concern that there was confusion on the vote for retained placenta. RAC member asked what was voted on. D. Selover responded that knowing that the evidence states 60 minutes, the vote was to keep. **Follow-up: Discussion and vote for retained placenta greater than 60 minutes is noted on pages 3 and 4.**

It was noted that staff will work on preparing a document that identifies RAC member vote outcomes.

RAC member asked to re-vote on this risk factor. It will be considered for the next meeting.

Next meeting is scheduled for March 8 at 1:00 p.m.

RAC adjourned at: 2:50 p.m.