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Birthing Center Rule Advisory Committee
March 2, 2020
9:00 a.m. – Room 1-B

RAC MEMBER ATTENDEES	
Silke Akerson	Oregon Midwifery Council
Kaylyn Anderson (phone)	Consumer
Laura Erickson	Alma Midwifery Services
Jennifer Gallardo	Andaluz Birth Center
Hermine Hayes-Klein	Oregon Association of Birth Centers
Desiree LeFave	Bella Vie Birth Center
Meredith Mance (phone)	Aurora Birth Center
Samie Patnode (phone)	Board of DEM
Margaret Porter (phone)	Bella Vie Birth Center
Alice Taylor	American Association of Birth Centers
Willa Woodard Ervin (phone)	Rogue Birth Center
Michelle Zimmerman-Pike	American College of Nurse Midwives
OTHER INTERESTED PARTY ATTENDEES	
Debbie Cowart	Growing Family Birth Center
Sharron Fuchs	Public
OHA Staff	
Mellony Bernal	Admin. Rules and Leg. Policy Analyst; Health Care Reg. & Quality Improvement
Anna Davis	Survey and Certification Manager; Health Facility Licensing & Certification
Rebecca Long	Paramedic/Health Educator; EMS and Trauma Systems
Dana Selover	Section Manager; Health Care Regulation & Quality Improvement

Welcome
Mellony Bernal opened meeting, reviewed housekeeping items and members introduced themselves.

January 24, 2020 Birthing Center RAC meeting notes
Dana Selover asked RAC members whether there were any comments or proposed changes to the January meeting minutes. RAC member pointed out a spelling error in an individual's name. Minutes will be updated to reflect correct spelling as follows: Kailia Wray. No further comments were made.

Overview

D. Selover reviewed agenda and provided an overview of where the RAC is in the process of the rules including the voting process on the risk factors from the last meeting.

- RAC member inquired when the RAC would further discuss prior cesarean section risk factor. D. Selover remarked that more preparation for that discussion is needed as the agency needs time to consider the articles that have been forwarded to the program.
- D. Selover noted that the RAC will continue to discuss the risk factors in the order they appear on the table and use the straw poll consensus options used from the last meeting.
- RAC member remarked that in terms of the polling, she will always promote an integrated system of care and shared decision making. While some risk factors are appropriate to exclude birth from a birthing center, they may not be appropriate to exclude from receiving care from a birthing center prior to birth. RAC member stated that evidence supports that care in a birthing center has better outcomes, lower pre-term birth rates, fewer c-sections, etc. even with a planned hospital delivery.
- Another RAC member shared that birthing centers fill an important gap in rural Oregon where there are limited prenatal care options. It was asserted that pregnant women in rural Oregon would be significantly safer and better served receiving prenatal care in their local community even if planning for a hospital delivery.
- D. Selover noted that allowing birthing centers to provide prenatal care even when certain risk factors are present is an action item that is still under consideration.

Risk Factor Table 1 – Risk Factors for EXCLUSION AT ADMISSION

Discussion and Polling

Maternal History

<u>Retained placenta requiring surgical removal</u> (exclusion at admission)

Discussion:

- RAC member suggested that more clarity is needed around the term "requiring surgical removal." There may be a wide range of issues with a retained placenta, not all of which include placenta previa or accreta.
- D. Selover noted that there are a wide range of issues on all risk factors and that a birthing center's policy and procedures, conversations with clients, assessing a client's history, and documentation are all important to consider when deciding whether a birth is appropriate or not at a birthing center. Consideration needs to be given to both how a birthing center will implement and how the Authority will regulate.
- RAC member reiterated that more definitions or clarity is needed because there is a difference between a denotative and connotative definition of surgery. Someone going into the O.R. does not necessarily mean the placenta had to be surgically removed.
- RAC member shared that "requiring surgical removal" is fairly clear and that charting could show 'manual' removal versus 'surgical' removal.
- D. Selover asked RAC members to consider interpretive guidance as a way to address some of the issues being raised as opposed to actual rule text.

- RAC member suggested amending to state retained placenta requiring surgical removal with instruments.
- RAC member stated that these kinds of issues are why most risk factors need to be moved to consultation. There are too many variables to keep as an absolute risk factor. Midwives and providers need to be trusted to consult on individual situations.
- Poll Results:
    - 0% - I can say an enthusiastic yes to the recommendation (or action).
    - 18% - 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.
    - 27% - 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.

Prior to voting on moving factor to consultation, D. Selover shared the following:

- There is both the expectation that there is clarity around what low risk is and what it is not;
- There are some factors that are not appropriate without surgical back-up. There is no surgical back-up nor intensive care at a birthing center;
- Consider low risk, high harm; low frequency, high harm. Some things may be rare but if it does happen, there is no time to react nor to get the client transferred in time. There needs to be a balance. Example given of a patient going to a trauma hospital versus a non-trauma hospital. The trauma hospital is prepared with appropriate staffing, services, and equipment.

Discussion:

- RAC member noted the importance of having access to the hospital records to determine possible surgical removal or other.
- RAC member remarked that the way this risk factor is written presents a problem. It was stated that most members would agree that placental accreta or percreta are appropriate exclusions. The term "surgical removal" can include much more which may not be appropriate exclusions. RAC member suggested that it would be more appropriate to define the risk factor to include the term(s) placental accreta, increta or percreta.
- RAC members and staff discussed voting poll options and D. Selover noted that this is an advisory committee, and members are giving advice on how the rules could be changed for the better. It was further noted that concerns can be addressed through added definitions, additional information, interpretive guidance, etc. Further discussion ensued regarding clarifying voting options.
- RAC member remarked that they would be embarrassed to consult with a provider about potential risks when identifying in a record something like a placenta falling out or using an instrument such as forceps. Providers have very little time for consultation as it stands now. It was suggested that the risk factor should be history of accreta for absolute exclusion. The provider should be trusted to understand a previous 'op' report and be

able to determine possible risk. If there is something in the report that would require a consultation, then a consultation should occur.

- RAC members concurred with previous suggestion that the absolute risk factor should be previous history of placenta accreta, increta or percreta. The following vote was taken:
    - **Previous history of placenta accreta, increta or percreta** (exclusion at admission)
        - 73% - I can say an enthusiastic yes to the recommendation (or action).
        - 18% - 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.
        - 9% - 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.

PREVIOUS FETAL HISTORY

Neonatal encephalopathy (exclusion at admission)

Discussion:

- D. Selover noted that the tables currently under review were based on the 2015 HERC guidance. Since that time, HERC has proposed moving neonatal encephalopathy to the consultation criteria.
- RAC member noted that the HERC recently took steps to reconsider current guidance and the birthing center rules should not be more restrictive than the HERC. RAC member concurred that this factor should be moved to consultation.
- RAC member remarked that neonatal encephalopathy may result from a variety of different sources and would thus may exclude many women.
- RAC member suggested that this factor should be removed altogether including from consultation. It was suggested that the consultation list will be so long that it will result in increased costs. It was further stated that it will not improve outcomes since there is no problem given current laws.
- RAC member stated that with respect to consultation, it's not about asking a physician for permission. Regardless of risk factors, a woman has the choice to make her own medical decisions based on receiving relevant information about the safest options available. RAC member further stated that the HERC guidelines are for purposes of payment only and not about who can give birth at a birthing center. RAC member asked whether there was any data suggesting bad outcomes in Oregon and if so, it is the state's obligation to share that data. D. Selover responded, as indicated in previous meetings, the HERC guidelines were used as basis for alignment and is the agency responsible for looking at health evidence across the board - not evidence limited to Oregon. Just because something hasn't occurred in Oregon doesn't mean that the risk is not relevant.

- RAC member suggested that more detail around this topic was necessary since encephalopathy is a broad term (could be microcephaly in previous pregnancy, hydrocephalus, hypoxic ischemic encephalopathy, etc.)
- RAC concurred with comments about both informed choice and that evidence should not be Oregon based only, or even nationally. HERC does and has looked at international studies. The fact that consultation is an option is very important and relevant to families who have been faced with previous adverse outcomes. Consultation leads to shared decision making based on as much evidence that can be obtained.
- RAC member cited evidence to support not including this factor as a full exclusion. Both the British Medical Journal and the American College of Obstetricians and Gynecologists state that this can occur with various etiologies. Recent research has focused on optimal resuscitation practices for babies with cardiorespiratory depression, such as delayed cord clamping after establishment of ventilation and resuscitation in room air. These are all standards of care within midwifery practice and birthing center practice.

  Source(s):
  https://fn.bmj.com/content/102/4/F346?utm_campaign=adcfn&utm_source=trendmd&utm_medium=cpc&utm_content=consumer&utm_term=1-A

  https://www.uptodate.com/contents/etiology-and-pathogenesis-of-neonatal-encephalopathy?search=neonatal%20encephalopathy&topicRef=6216&source=see_link

- Based on discussion, D. Selover recommended voting on Neonatal Encephalopathy as consultation requirement not an exclusion.
  - **Previous fetal history – neonatal encephalopathy as a consultation requirement not an exclusion at admission**
    - 27% - I can say an enthusiastic yes to the recommendation (or action).
    - 9% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
    - 18% - 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.
    - 27% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

Placental abruption with adverse outcomes (exclusion at admission)

Discussion (exclusion):

- RAC member shared that placental abruptions could be associated with secondary factors, such as a woman with a high Amniotic Fluid Index (AFI) due to fetus with an anomaly. During the next pregnancy, ultrasounds and tests are normal so the individual should no longer be at risk for placental abruption.

- RAC member indicated that an additional secondary factor could be domestic violence or other injury.
- RAC member indicated that placental abruption could be due to hypertension that occurred in first pregnancy but may not be exhibited in subsequent pregnancies.

Discussion (consultation):

- RAC member indicated that she consults on many things and adding additional factors will overwhelm her practice and hesitates to continue to add everything to consultation. Additionally, RAC member stated it's hard to consider when consultation has not been defined.
- RAC member suggested that this factor is not necessary since women who have had a placental abruption have likely received additional information at the time of the abruption from their provider about how likely this would occur again.

D. Selover suggested voting on the following:

- **Retain placental abruption with adverse outcomes on ANY table?**
    - 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.
    - 9% - 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.
    - 91% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

Stillbirth or neonatal death (unexplained) or previous death related to intrapartum difficulty (exclusion at admission)

Discussion:

- D. Selover noted that the HERC has revised its guidance that is out for comment and which now specifies "Prior stillbirth/neonatal death."
- RAC member indicated that this factor should be removed completely as each pregnancy is different. The parents will know more about history and records can be obtained to identify what happened in previous delivery.
- RAC member concurred with previous statement as it can be related to so many different possibilities. RAC member indicated that several different studies look at recurrent rates of stillbirth. She further stated that while it is known there can be an increase in reoccurrence of stillbirth, it's not reoccurrence that is the issue, rather it's whether the birth site changes the rate of reoccurrence and what affect it has on actual outcomes. She further stated that evidence does not support that a change in birth site or treating these pregnancies as high risk will improve outcomes. There are two different studies that show there's little evidence that the approach prevents any stillbirth in the next pregnancy and still increases morbidity from unnecessary interventions. Including this risk factor will create additional issues by not allowing access to care for these families.

RAC member further noted that there is agreement among multiple bodies of study that hands on care with a provider who listens to needs, takes and spends time with individual in appointment and provides strong emotional support does help these families. This is a strong principle of the midwifery model of care. Having this factor as an exclusion will decrease safety options for families.

Source(s):
https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.14424%4010.1111/%28ISSN%291471-0528.JANUARY2016OBESITYANDWOMENSHEALTH

https://www.bmj.com/content/350/bmj.h3080.full.pdf+html

- RAC member indicated that this factor is appropriate for consultation as it's currently worded. If the text were to change to just "prior stillbirth/neonatal death," then it should be removed entirely.

D. Selover suggested voting on aligning with the revised HERC guidance as follows:

- **Amend text as "Prior stillbirth/neonatal death" and move risk factor to consultation.**
  - 27% - 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.
  - 9% - 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.
  - 45% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

- **Removing "prior stillbirth/neonatal death" altogether.**
  - 55% - I can say an enthusiastic yes to the recommendation (or action).
  - 18% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
  - 18% - 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.
  - 9% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

CURRENT PREGNANCY COMPLICATIONS

Anemia – hemoglobin < 8.5 g/dL (exclusion at admission)

Discussion:

- RAC member asked at what point in pregnancy is this factor referring to. D. Selover responded at birth (admission for labor.)
- Vote - **Anemia – hemoglobin < 8.5 g/dL (at admission for labor)** [exclusion at admission – absolute risk factor]
    - 82% - I can say an enthusiastic yes to the recommendation (or action).
    - 18% - 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.

Bleeding Disorder – Thrombosis, thromboembolism, thrombocytopenia (platelets <100,000), other (exclusion at admission)

Discussion:

- Current rule specifies "Thrombosis, active/current" with no reference to platelet counts

- Proposed revised HERC guidance has revised and separated to specify the following:
    - Suspected or diagnosed thrombosis or thromboembolism and
    - Thrombocytopenia (platelets <100,000)

  D. Selover asked if these factors should be kept together as 'bleeding disorder' or separated?
- RAC member suggested removing the reference to platelets <100,000 stating that many women may have idiopathic thrombocytopenia that can safely be cared for out-of-hospital [<75,000 but not less than 50,000 may be better choice.] Other bleeding disorders should be considered under consultation as there is a very wide range of categories some of which can be dangerous or others that can be easily managed outside of the hospital setting.
- RAC member suggested removing platelet count altogether as is currently established in rule. Providers should know what a normal or abnormal platelet count is.
- RAC member suggested moving risk factor to consultation and in this case the consult should be with a hematologist.
- RAC member expressed concern about use of the term "stable" noting it is neither useful nor accurate as some stable conditions may be a problem.

D. Selover recommended voting as follows:

- **Suspected or diagnosed thrombosis and thromboembolism** (exclusion at admission)

    - 45% - 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.
    - 9% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.
- **Thrombocytopenia <100,000** (exclusion at admission)
    - 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.
    - 9% - 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.
    - 36% - 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.

- **Thrombocytopenia <75,000** (exclusion at admission)
    - 83% - 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.
    - 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.
    - 8% - 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.

D. Selover recommended not including nor voting on "other bleeding disorder." RAC members concurred.

Diabetes (exclusion at admission)

Discussion:

- D. Selover noted that the risk factor on the proposed table reads as follows: Diabetes – Gestational – uncontrolled or controlled with medication; and then listed as a separate bullet - Type I or Type II.

- RAC member remarked that under current rules birthing centers can take care of persons with Type 2 diabetes if the person does not need medication to control it.
- RAC member suggested that someone who is taking metformin should be able to be taken care of out-of-hospital. It was suggested that the risk factor be edited to allow persons with Type 2 diabetes or gestational diabetes treated and controlled with oral medications could have an OOH birth.
    - It was noted by a RAC member that pursuant to the Board of Licensed Direct Entry Midwifery, Type 2 diabetes or gestational diabetes treated with insulin or oral medications is an indication for transfer.
    - RAC member commented that while a pregnant woman could proceed with normal fetus growth and extra assessments, such as ultrasounds, can ensure normal growth, it's the possible risk of hypoglycemia after birth that may be best monitored in a hospital setting.
    - RAC member suggested that absolute exclusion of care may not be appropriate as many women receive continued support, nutritional guidance, etc. from birthing centers; however, delivery at a hospital may be what a woman opts for given increased risk for hypoglycemia based on education and shared decision making.

D. Selover recommended voting as follows:

- **Retain as written – Diabetes * Gestational – uncontrolled or controlled with medication; * Type I or Type II** (exclusion at admission)
    - 18% - I can say an enthusiastic yes to the recommendation (or action).
    - 9% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
    - 18% - 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.
    - 36% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.
- **Amend – Diabetes * Gestational (uncontrolled or controlled with other than oral medication); * Type I; or * Type II (uncontrolled or controlled with other than oral medication) and move to consultation**
    - 64% - I can say an enthusiastic yes to the recommendation (or action).
    - 9% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
    - 18% - 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.
    - 9% - 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.

Drug or Alcohol Use with High Risk Factor for Adverse Effects to Fetal or Maternal Health (exclusion at admission)

Discussion:

- D. Selover noted that the initial revision proposed by HERC included a reference that persons receiving medication-assisted treatment for opioid use disorder would be a consultation requirement. This has been removed from the latest HERC proposal that is currently out for comment.
- RAC members had no further comment.
- Vote as written:
    - 73% - I can say an enthusiastic yes to the recommendation (or action).
    - 18% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
    - 9% - 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.

Eclampsia or Pre-eclampsia (exclusion at admission)

Discussion:

- None
- Voting as written:
    - 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.

Fetal (risk factors) (exclusion at admission)

Discussion:

- D. Selover noted that there are several factors listed and asked if the risk factors should be discussed separately. RAC concurred.

Abnormal fetal heart rate, doppler, surveillance studies (exclusion at admission)

Discussion:

- D. Selover noted that the HERC proposed revision had initially included the following under 'fetal monitoring and movement' which would require transfer:
    - Abnormal fetal heart rate, Doppler, or surveillance studies
    - Repetitive or persistent abnormal fetal heart rate pattern during labor
    - Inability to adequately follow an intermittent auscultation protocol
- RAC member stated that it's important to consider pregnancy and labor separately. Additionally, it was stated that more specificity, or definitions are needed based on how it is currently written. A time frame, or reference to persistency is necessary as there are some disqualifiers that are very temporary and could be resolved without intervention.
- RAC member concurred adding more specificity about time frame.
- RAC member provided examples of fetal heart rate issues where intervention wouldn't have been necessary and suggested the risk factor be moved to consult. Other RAC members concurred with consult.
- RAC member commented that 'abnormal surveillance studies' should remain in the exclusion category.
- RAC member suggested having these factors be listed under consult. Other RAC members concurred.
- RAC member asked that it be clear that when a person with a risk factor requires transfer and the issue resolves, the person can come back for midwifery care.
- RAC members suggested adding the term 'unresolved' or 'not resolved at onset of labor.' Some RAC members disagreed with adding 'at onset of labor.'
- RAC member expressed concern that 'abnormal fetal surveillance' may be too broad and too restrictive especially when a consultation would be beneficial.
- Another RAC member responded that the term 'unresolved' is concerning. Birthing centers should not wait until something is resolved in certain cases before it's evaluated. Consider "persistence" for heart rate. Surveillance studies that are marginal should not be considered abnormal.
- RAC members discussed types of testing and how some may be interpreted. RAC member indicated that consultation would take care of many concerns discussed.

D. Selover asked that RAC members do the following:

1) Submit to M. Bernal possible language changes in this category for future voting including if moving to consultation what the language would look like;

2) Be prepared at next meeting with concrete language changes;

3) Submit information that would support changes to risk factors.

NEXT STEPS

RAC to submit possible changes and make recommendations for language on each item.

Next meeting is scheduled for April 17 at 9:00 a.m. RAC member requested that the meeting be changed because some birthing centers will not be available to attend. M. Bernal will submit new meeting poll.

Meeting adjourned at 12:00 p.m.