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Birthing Center Rule Advisory Committee
November 29, 2021
10:00 a.m. via Zoom

RAC MEMBER ATTENDEES	
Colleen Forbes	LDM and former chair of the Board of Direct Entry Midwifery
Hermine Hayes-Klein	Oregon Association of Birth Centers
Jennifer Gallardo	Andaluz Waterbirth Center
Karen DeWitt	Oregon Association of Naturopathic Physicians
Laura Erickson	Alma Midwifery Services
Lynette Pettibone	American Association of Birth Centers
Margy Porter	Bella Vie Gentle Birth Center (Clinical)
Silke Ackerson	Oregon Midwifery Council
Susan Heinz (for Desiree LeFave)	Bella Vie Gentle Birth Center (Administrative)
Willa Woodard Ervin	Rogue Birth Center
OTHER INTERESTED PARTY ATTENDEES	
Bill Bouska	Samaritan Health Services
Christina (Baldisseri) Clay	CareOregon; LDM
Janette Gyesky	Bend Birth Center
Maegan Pelatt	CareOregon
Ray Gambrill	AllCare Health; MD
Safina Koreishi	CareOregon
Stefan Shearer	CareOregon
OHA Staff	
Anna Davis	PHD-Health Facility Licensing & Certification
Barbara Atkins	PHD-Facility Planning & Safety
Dana Selover	PHD-Health Care Regulation & Quality Improvement
Diane Quiring	Health Systems Division – Medicaid Programs Unit
Lacey Martinez	PHD-Health Facility Licensing & Certification
Mellony Bernal	PHD-Health Care Regulation & Quality Improvement
Rebecca Long	PHD-Emergency Medical Services and Trauma Systems
Samie Patnode	Health Licensing Office, Board of Direct Entry Midwifery

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, member of public, or staff of Oregon Health Authority into the Chat.

Review of October 18th Meeting Notes

Dana Selover asked RAC members to submit any comments or feedback on the meeting notes via E-mail.

Review of Physical Environment – OAR 333-077-0220

Barb Atkins, Architectural Plans Examiner for Facility Planning and Safety, introduced herself. RAC members were reminded that initially the Authority proposed adopting the Facility Guidelines Institute building standards, but based on concerns registered by RAC members, the Authority proposed amended rules to align with the Commission for the Accreditation of Birth Centers (CABC). These amendments had been previously shared with RAC members and a few comments were received via E-mail. This is an opportunity to receive final feedback on suggested changes.

Discussion:

- Page 6, row 1 – RAC member inquired whether proposed rule language requires that every bathroom and birth room be wheelchair accessible when previously only one bathroom and one birth room needed to be wheelchair accessible. Staff replied that it is expected that each private birth room have a bathroom that is accessible to persons with disabilities unless the birthing room is located on a floor not accessible to persons with disabilities. It was noted that the CABC requires that at least one bathroom be wheelchair accessible; however, Oregon Building Codes requires that all single occupancy toilet rooms or bathrooms be handicap accessible. It was further noted that to convert a house into a birth center, it must be converted from a residential occupancy to a business occupancy, and therefore must comply with the federal Americans with Disability Act and state building codes.
    - RAC member stated concerns that every birth room must be big enough for wheelchair access which could result in fewer birth rooms to accommodate the extra space. Birth centers with multiple rooms on the main floor could be adversely impacted.
    - RAC member noted that based on risk criteria, an accredited birth center may not have disabled people in its care, especially physically disabled needing wheelchair access. Clients must be ambulatory to give birth at a birth center. Accessibility is more about a partner who may be physically disabled which is why the CABC recommends one.
    - Further information is needed on whether a physical disability is a risk criteria that would require a client be transferred.
    - RAC member inquired about whether the standard applies to new construction or remodels only. Staff reminded RAC members that existing, licensed birth centers will not be required to comply with the new physical environment rules. Existing centers are licensed and surveyed based on the rules in effect at the time of initial licensure. Remodels that completely redesign a birth room or remodels that affect more than 50% of existing space would be subject to revised rules. Birth centers subject to initial licensure or major renovation will also be impacted by these rules. A birth center may apply for a waiver of physical environment standards.
    - Several comments were posted via chat by RAC members including:

        - Concern about the need to convert every floor-level birth room to having accessible with the bathroom. Previously only needed 1 accessible room. Proposed changes would greatly affect facility.
        - Concern noted that "we don't want to pull up the ladder on new birth centers opening." Opening a birth center under current laws is not easy and rules should not make it even harder for access.
        - Confirmation that it is very uncommon for a patient that is not ambulatory to meet birth center criteria otherwise.
        - Oregon Midwifery Council support of comments stated by birth center owners.
        - Concern noted with proposed accessibility language and having a single room that is accessible should be sufficient.
- Page 7, row 1 – with regard to appropriate flooring, staff clarified that the intent is not to "ruin the character of the building" rather asking for modest accommodations, for example not having carpet or slippery tiles in a toilet room.
- Page 7, row 2 – RAC member had previously shared concerns about ability to have a self-dispensing ice machine. Staff clarified that a refrigerator with an ice machine that you place a cup to is considered self-dispensing and would be acceptable. Freezer trays of ice where anyone can handle would not be acceptable.
    - RAC member provided example of an ice maker with a scoop and staff indicated that for this rule, this would not be adequate. RAC member asked other centers for examples of type of ice dispensers used.
    - Via chat, the following comments were provided:
        - Refrigerator with ice dispenser
        - Purchase on Amazon $150
        - Small pellet ice machine but it still has a scoop
    - Staff noted that the purpose of this rule is to ensure proper use and infection control.
- Page 7, row 3 – Staff noted that an exam room is not required; however, if a birth center provides an exam room, the room must have adequate space to accommodate clients, family members, and staff. Furthermore, for renovation projects of existing licensed space if a handwash station cannot be accommodated in an exam room, an alcohol-based hand rub dispenser will be required aligning with the previous discussion about birth rooms. It will be expected that for new construction, seeking new licensure, or major renovation (affecting more than 50% of the center) of existing licensed spaces, a handwash station be added. A birth center may request a waiver from this requirement.
- Page 8, row 1 – With regard to laundry service, a RAC member had previously commented that use of the term "adequately sized" and "adequate storage" is appropriate.
    - RAC member commented via chat support of use of term 'adequate.'
- Page 9, row 2 – With regard to clean and dirty laundry, the current proposed language refers to requiring 'adequate storage' to meet the needs of the birth center and that areas must be designated as clean or dirty. RAC member previously commented that 'adequate storage' could be interpreted very differently. Another RAC member previously commented that the term may be difficult to define, however, it is expected that each center has different needs. Staff asked RAC to consider language that specified for every birth room bed, a birth center shall provide 10 sq.ft. or cubic ft so that a minimum requirement is set. Discussion:
    - RAC member comment that it depends on what the number is. Smaller birth centers may be impacted based on how much floor space they have. Staff indicated that if a number is set it would likely be around 10 sq.ft. A 10 sq.ft closet is 5 ft wide and 2 ft deep. The purpose is to ensure that a birth center has enough storage space so not everything is left on a dresser or countertop, etc.

    - RAC member asked if an armoire would be considered storage. Staff responded yes if it is noted as storage.
    - RAC member commented via chat support of use of term 'adequate.'
    - RAC member asked if the storage space needed to be attached or in the birth room? Staff responded that the rule does not require such and it can be anywhere in the birthing facility.
    - RAC member via chat noted that setting a specific number is not necessary and potentially cumbersome.
    - RAC member asked via chat "is that much red tape necessary?"
- Page 9, row 3 – for purposes of holding soiled material that is secure from public access, staff noted that the term 'adequately sized' for storage space is noted here as well, and if a number is chosen for laundry (as discussed above), the same number would be noted here as well. It was further noted that it would be 10 sq.ft total (clean and dirty cumulative) not for each.
    - RAC member remarked that 10 sq.ft. for each birth bed for soiled material is more concerning than general storage. Soiled material is in the laundry room. Staff responded and reiterated that it would be a combined 10 sq.ft. for both clean and soiled combined. For example, 8 sq.ft may be for clean and supplies and 2 sq.ft. for soiled. (2 sq.ft. is about the size of a linen hamper.)
    - RAC member noted via chat that they have multiple different areas (cabinets, dressers, etc.) for storage, not just one, so it would be difficult to measure. Keeping language vague would be more appropriate.
- Page 9, row 3 – continued – Staff noted that a handwash station with soap and single use paper or cloth towels must be provided within 20 ft of soiled material in order to wash hands after handling soiled material.
- Page 10, row 3 – This rule specifies that there is a means for sterilizing equipment in accordance with infection control rule 333-077-0190. The infection control rule text was placed in the chat.
    - RAC member indicated that some birth centers have autoclaves while others use a pressure cooker which should be acceptable. It was further stated that there are sterilization packs that turn a different color to ensure proper sterilization.
    - Two RAC members via chat indicated that a pressure cooker is adequate in a birth center.
    - RAC member indicated via chat that the Commission for the Accreditation of Birth Centers has stringent rules for autoclave including spore testing, record of cleaning, etc.
    - Another RAC member responded via chat that a pressure cooker "may" be adequate for sterilization depending on the PSI and its ability to maintain adequate pressure for the requisite amount of time.
    - It was noted that for purposes of the built environment, the plans examiner would not survey to see if the equipment was operating according to rule. Health Care Surveyor staff noted that it is possible that a pressure cooker could be used for sterilization; however, the pressure cooker must have manufacturer instructions that will explain temperatures and times necessary for sterilization. Manufacturer instructions must also explain routine maintenance and cleaning. The facility would need to develop policies to maintain the pressure cooker for sterilization use.
- Page 10, row 4 - Specific to fire prevention and requires that medical gases such as oxygen and nitrous oxide must meet specific storage requirements must be met. D. Selover asked staff how much of this rule is above and beyond existing requirements for any business occupancy. Staff responded that the NFPA 99 is the nationally recognized code for all health

care facilities. An office such as a doctor's office that does not require state licensure would defer to local fire inspector. It was further noted that these requirements are also from the Office of the State Fire Marshall and not the Authority. It was further noted that the local fire inspector may ask for more which is outside of the Authority's purview.

- Page 11, row 1 - Requires that a toilet facility for staff may not be the same toilet room in the birth room. A minimum of 1 toilet room for the public is required. RAC member had previously indicated that there would be no way to meet this standard as the only toilet available to the public would be within a birth suite. Staff noted that in this case the birth center could apply for a waiver. Staff reminded RAC members that these proposed rules only apply to new construction, initial licensure, or major renovations.
- Page 11, row 2 - Relating to play area is based on CABC standards and is not a designated room but rather a space for children to play.
- Page 11, row 4 – Requires a telephone be made available to families to access emergency assistance and that signage be posted. RAC members had previously stated that given the age of cell phones, this rule is not necessary. Staff noted that all health care facilities that the Authority regulates requires *access* to a telephone. There is still a generation of people who may not have a cell phone or persons may forget or not have a charger for a cell phone.
- Page 12, row 2 – Staff work area shall be provided to discuss confidential information. Staff noted the rule does not require the space be on the same floor, only that space be available so staff can work privately and discuss protected patient health information that is secure from public.
    - RAC member noted that there is access to areas where information can be privately discussed.
    - RAC member asked whether extra clarification can be written into the rule so in the future it is note interpreted differently. Additional clarification may be to clarify that the space needs to be outside the birth room.
    - Staff noted that with other rules – room means walls with a door versus area means a designated space.
    - Question was raised about secure from public access. Staff will clarify that medical records must be secure from public access.
    - It was noted that the Authority uses written interpretive guidance to provide further clarification on rules.

Staff encouraged RAC members to send any additional comments to M. Bernal via E-mail.

ACTION: Consider identifying minimum space requirements for clean, soiled, and storage spaces. Clarify that medical records must be secure from public access.

Risk Factor Table I – Risk Factors for <u>EXCLUSION AT ADMISSION</u>

CURRENT PREGNANCY COMPLICATIONS

D. Selover opened discussion suggesting that the following risk factors be discussed as a group:

Placental abruption/abnormal bleeding
Low lying with 2 cm or less cervical os at term; previa; vasa previa
Recurrent antepartum hemorrhage
Uteroplacental insufficiency

RAC member indicated that abnormal bleeding should be removed from placental conditions listed and considered in a different category altogether. It is very vague and can mean many different things.

- RAC member indicated support of abruption as an absolute risk criterion.
- RAC members were asked by staff to indicate whether 'abnormal bleeding' should be retained next to placental abruption. No RAC members commented that it should remain.
- RAC member suggested via chat that "abnormal bleeding along with recurrent antepartum hemorrhage" should be moved to consult criteria, not an absolute risk factor. Another RAC member commented that the definition of hemorrhage (1,000 cc's or enough bleeding that there is a physiologic response) could be why it's listed as an absolute risk factor. It's not just some blood loss but an actual hemorrhage.
- RAC member indicated that the definition of recurrent antepartum hemorrhage in the Journal of Prenatal Medicine is 'bleeding from the genital tract in the second half of pregnancy' and is not defined in the same way as a postpartum hemorrhage (1,000 cc's or more of bleeding.) It was noted that half the time antepartum bleeding may be the result of a serious underlying cause but is not always the case, thus moving to consultation would be appropriate.
- RAC member indicated via chat that antepartum hemorrhage is different than "spotting."
- RAC member stated via chat that it is assumed to be a hemorrhage.
- RAC member stated agreement that based on the definition discussed, to move to consult.

RAC member suggested changing language relating to low lying placenta based on information shared by Dr. Duncan Nielson. Rather than stating "at term," (which is vague) the language should be changed to "Low lying with 2 cm or less of cervical os *at last ultrasound prior to start of labor.*"

- RAC member concurred agreeing that there is a grey area for the definition of 'at term.' The clearer rule language can be the better.

The following polls were completed:

<u>POLL: Retain placental abruption as an absolute risk factor. Results:</u>

- 89% - 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.
- 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.

<u>POLL: Retain low lying placenta with 2 cm or less of cervical os (removing reference to 'at term') – at last ultrasound prior to start of labor. Results:</u>

- 78% - 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.

- 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 uteroplacental insufficiency as an absolute risk factor. Results:

- 70% - I can say an enthusiastic yes to the recommendation (or action).
- 30% - 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.

For purposes of polling, staff asked the RAC whether anyone had ideas on how to define 'abnormal bleeding' or 'recurrent antepartum hemorrhage' or other suggestions.

- RAC member noted that the language would need to reflect that a "Recurrent antepartum hemorrhage" overlies with another risk factor.
- RAC member noted that the most common causes for recurrent antepartum hemorrhage are already listed elsewhere on the risk factor tables, i.e., abruption and previa. For all others, it should go to consult criteria. For example, recurrent antepartum hemorrhage in the absence of placenta abruption or placenta previa would be a consult.
- Staff asked about quantifying abnormal bleeding and what would the language look like.
- RAC member via chat suggested "Abnormal antepartum hemorrhage that does not resolve"
- RAC member concurred with suggested language above but noted a down-side of putting a quantity like 500 cc's might lead some people to believe that a workup isn't necessary until that quantity is reached. Providers should want to identify the source of bleeding regardless of the quantity. It was also noted that this should be consult criteria.
- RAC member indicated via chat that clients with abnormal antepartum hemorrhage are sent for an ultrasound and it has to resolve, and everything normalize, or the client is risked out.
- RAC members via chat concurred with comments above.
- RAC member stated via chat that the Board of Direct Entry Midwifery rules indicate consult for second or third trimester bleeding. RAC questioned whether it was bleeding or abnormal bleeding – **Follow-up: OAR 332-025-0021(17)(g) specifies: Indication for consult – Antepartum: Second or third trimester bleeding.**
- RAC member suggested "Unresolved antepartum hemorrhage of unknown cause." RAC via chat agreed with this wording.

POLL: Retain unresolved antepartum hemorrhage of unknown cause as an absolute risk factor

Results:

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

Discussion:

- RAC member stated that the poll was confusing and thus did not vote. More discussion was requested and asked RAC members why 'unknown' is important to include. RAC member responded there are a few 'known' causes of antepartum hemorrhage and suggested that part of the confusion is per literature antepartum hemorrhage really means any antepartum bleeding. There are known causes of antepartum bleeding that do not resolve and would not risk a person out (e.g., cervical polyp that causes bleeding during intercourse.)
- RAC member suggested via chat, "I think moving to the LDM language for consult would be a simple solution."
- RAC member via chat stated that consultation would be perfect because there are many reasons for bleeding some of which are benign.

POLL: Move recurrent antepartum hemorrhage to consultation

Results:

- 78% - 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.
- 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.

Prelabor Rupture of Membranes > 24 hours

RAC member stated that this is a consult criterion in the Health Evidence Review Commission (HERC) guidelines. There is no reason why this should be an indication to transfer. The risk around prelabor rupture of membranes (PROM) is complex and deserves informed choice between client and midwife.

- RAC concurred and restated this is a complex issue which a midwife will discuss the risks with their client and chart. There is clear data on the safety of expectant management with PROM up to 72 and even 96 hours. Would support removing from the absolute risk factor table.
- RAC member concurred with comments and suggested removing reference to hours or possibly include 'with signs of infection.' RAC member further suggested that the risk factor be removed altogether and should not be either an absolute risk factor or consultation requirement as this condition is something that is dealt with all of the time.
- Additional suggestions noted by RAC members via chat included:
    - PROM with signs of infection or beyond 72 hours
    - Consult should be at 48-72 hours
    - Consult at 48 hour or transfer with signs of infection
    - No absolute and no consultation – don't want client to go anywhere where additional microbes could cause infection.
    - Prolonged PROM
- RAC member disagreed with suggestion that PROM include reference to infection. Infection is already an indication for transfer. It was further stated that PROM should not be in any risk factor table, but if it was listed it should be under consultation.
- Several RAC members commented via chat agreement with above statement.

<u>POLL: Move prelabor rupture of membranes > 24 hours to consult.</u>

<u>Results:</u>

- 0% - I can say an enthusiastic yes to the recommendation (or action).
- 25% - 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.
- 13% - 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.
- 63% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

Refractory hyperemesis gravidarum

RAC member stated that its important that the definition of 'refractory' be understood. Hyperemesis gravidarum should not be a 'risk out' however 'refractory hyperemesis' (when treatment is not effective; significant weight loss) should be a risk factor. It needs to be clear that hyperemesis alone does not risk someone out, but refractory would.

- RAC indicated via chat that hyperemesis gravidarum (HG) is defined as extreme vomiting during pregnancy associated with electrolyte imbalance, five-percent weight loss, or ketosis. It is estimated that this condition occurs in 0.3 to 10 percent of pregnant women, with a 0.8 percent hospital admission rate.
- RAC member indicated that persons with HG are managed at birth centers (IVs). Women with extreme vomiting can be cared for. The rule needs to be clearer.

- Staff noted that referring to 'refractory' means the persons is not responding to treatment and decompensating. RAC member concurred and noted that the literature clearly defines it as not a typical HG which can be severe, but refractory means it is unresponsive to treatment and could lead to eclampsia and other risk factors.
- RAC member via chat indicated that clients are typically already co-caring by the time of labor/birth and not able to even walk and not birthing out-of-hospital. HG is managed with IVs in labor and very different issue. HG should not be included.
- RAC member suggested changing to "Refractory hyperemesis gravidarum unresponsive to treatment." RAC member stated it would be redundant to have both refractory and unresponsive to treatment since refractory is defined as unresponsive to treatment.

POLL: Retain *REFRACTORY* hyperemesis gravidarum as an absolute risk factor

Results:

- 56% - I can say an enthusiastic yes to the recommendation (or action).
- 44% - 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.

Wrap Up

There will not be a December meeting. Next meeting is scheduled for January 10th at 1:00 p.m. Tables II and III are future agenda items.

- RAC member via chat inquired about plan for discussing risk factors that were previously deferred, e.g., VBAC. Staff responded that there are a few risks that will need to be discussed and brought back. RAC member noted that there are few risk factors in Table I that were not discussed at all and a meeting to discuss only these risk factors should be considered.
- Staff noted that a meeting poll will be sent out for a March meeting since February is legislative session. **Follow-up: After the RAC meeting, a decision was made to try and convene a February meeting if possible and meeting polls for February and March were sent to the RAC.**

RAC adjourned at: 11:55 a.m.