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 RAC
August 3, 2020
9:00 a.m. (Go-To-Webinar)

RAC MEMBER ATTENDEES	
Alice Taylor	American Association of Birth Centers
Desire LeFave	Bella Vie Gentle Birth Center
Hermine Hayes-Klein	Oregon Association of Birth Centers
Jennifer Gallardo	Andaluz Waterbirth Center
Julia Bailey (for Silke Ackerson)	Oregon Midwifery Council
Karen DeWitt	Oregon Association of Naturopathic Physicians
Kaylyn Anderson	Consumer
Margy Porter	Bella Vie Gentle Birth Center
Meredith Mance	Aurora Birth Center
Michele Zimmerman-Pike	American College of Nurse Midwives
Samie Patnode	Board of Direct Entry Midwives
Susie Corcoran	Aurora Birth Center
Willa Woodard Ervin	Rogue Birth Center
OTHER INTERESTED PARTY ATTENDEES	
Sharron Fuchs	Public
OHA Staff	
Anna Davis	PHD, Health Facilities Licensing and Certification
Barbara Atkins	PHD, Facility Planning and Safety
Dana Selover	PHD, Health Care Regulation & Quality Improvement
Lacey Martinez	PHD, Health Facilities Licensing and Certification
Matt Gilman	PHD, Facility Planning and Safety
Mellony Bernal	PHD, Health Care Regulation & Quality Improvement
Rebecca Long	PHD, EMS and Trauma Systems

Welcome and Overview

Mellony Bernal opened the RAC meeting which, due to the current COVID pandemic, is being conducted remotely by Go-To-Webinar. All future meetings will be conducted remotely until such time as it is deemed safe to begin holding in-person meetings.

Instructions for remote participation were given.

Roll call of RAC members was initiated and RAC members introduced themselves.

Review of March 3rd Meeting Notes

M. Bernal asked RAC members whether anyone had any comments or proposed changes to the March meeting notes. RAC member requested that the RAC member organizations be updated to reflect 'birth center' not birthing center. RAC member, Michelle Zimmerman-Pike, noted that she did participate in the March meeting and should be reflected as a participant.

Action – Minutes will be revised to reflect the changes noted.

Agenda Review and Update

- D. Selover noted that in addition to continuing the risk factor discussion and polling, staff will begin to review work completed on action items from previous RAC meetings.
- RAC members were reminded about the options for the straw poll consensus for the risk factor discussion. A copy of the risk factor table and the elements to be discussed were shared on the webinar.
- The OHA will continue to work through tables as currently drafted and will consider, with the RAC's input, which format might be best for adoption in final rules.
- The Board of Direct Entry Midwifery currently has rules out for comment – deadline to comment is 08/28/2020 by 12:00 PM – see: https://www.oregon.gov/oha/PH/HLO/Pages/Board-Direct-Entry-Midwifery-Laws-Rules.aspx
- The Health Evidence Review Commission will be reviewing the draft Out-of-Hospital Birth Guidance at its 08/13/2020 meeting. Information about the meeting and material can be found at: https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Meetings-Public.aspx

Risk Factor Table I – Risk Factors for EXCLUSION AT ADMISSION Discussion and Polling

For purposes of polling relating to the risk factors, the three questions that will be considered are:

1) Should the risk factor remain as an exclusion?
2) Should the risk factor be moved to consultation?
3) Should the risk factor be removed altogether?

Current Pregnancy Complications

Fetal: Blood group incompatibility with atypical antibodies, or Rh factor sensitization

Discussion:

- RAC member recommended moving to consultation as there are antibodies that have no effect on pregnancy.
- RAC member concurred with recommendation. As written, it is too broad of a category to be an absolute risk factor.
- RAC member concurred with previous statements. Even if there are antibodies that could affect the pregnancy, they could be titering so low that it is inconsequential.
- RAC member concurred that the risk factor should be moved to consult.
- RAC member concurred that consultation is appropriate.

Poll Question: Move blood group incompatibility with atypical antibodies, or Rh factor sensitization to consultation?

- Results:
  - 75% - 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.
  - 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: Gestational age – preterm (< 37 weeks + 0 days) or postdates (> 41 weeks + 6 days)

Discussion:

- RAC member asked whether this would allow a woman to be in labor at the birth center at 42 weeks. As written, staff indicated no. It was further noted that a woman who is in active labor prior to 42 weeks + 0 days could remain at the birth center if transfer is not safe or birth is imminent.
- RAC member indicated that the AABC rules allow a woman in labor to not 'risk out.'
- RAC member noted that the most recent HERC guidance clarifies that exclusion is ≥ 42 weeks 0 days unless the woman is already in active labor at 41 weeks 6 days. It was suggested that the risk factor be clarified further.
- RAC member agreed with clarification. It was further noted that clients may have normal fetal surveillance studies and may decline a transfer of care and questioned whether this would be considered abandonment of care. It was suggested to consider adding consultation in this scenario. Staff noted that birth centers have similar limitations now, and asked what makes this requirement different in terms of communicating than when other transfers also apply? RAC member indicated there is no evidence to support that there is an immediate risk to mom and baby that would require a transfer.
- Staff agreed that clarifying language for a woman in active labor prior to 42 weeks 0 days is appropriate.
- RAC member suggested referencing on-set of labor and indicated that CABC accredited birth centers have different rules. Women are being consistently monitored, have stress tests, etc. there isn't any additional risk by having them stay an extra day.
- RAC member inquired why there was a change from 36 weeks to 37 weeks? Staff noted change was based on alignment with the 2015 HERC guidance.
- RAC member indicated that it's important to remember that every provider has a more expanded scope than what may be allowed by HERC and limits the scope of providers who at a bare minimum can deliver between 36 weeks 0 days to 42 weeks 0 days. It is not in the best interest of clients to restrict providers further just because the birth may be happening in a birth center. It was further noted that there are times that a client may need to be transferred for a post-date induction and the hospital determines it is safe to delay for a few days. The birth center is then placed in a peculiar position if the client goes into labor prior to the scheduled induction date. As written, RAC member commented that the criteria do not serve safety and many factors are not being considered. It just changes the physical environment from a birth center to a client's home and does not serve the safety of the client.

- Staff noted that even though providers have different scopes, a birthing center setting is different than a hospital setting as the professional scope for an individual is different than a scope in a different type of setting. The Public Health Division is not limiting the scope of practitioners. It must apply the statutory requirement that a birthing center is primarily for low risk births.
- RAC member replied that a CPM is working in a low risk setting as well pursuant to statute. The discussion needs to include what the scope of practice is for each of the provider types and what is considered safe by community standards in out-of-hospital (OOH) births.
- RAC member concurred with comments of previous RAC member.
- RAC member concurred with previous two comments. It was noted that the HERC guidelines have restricted birth center scope where it has not restricted home birth scope. Birth center client scope of care should not continue to be restricted by taking away the additional weeks.
- Staff from the Health Licensing Office noted that during the public comment period for the DEM rules, there was a lot of discussion about the difference between 42 weeks and 43 weeks.
- RAC member stated that the HERC guidelines are not guidelines or regulations for scope of practice for any provider in any setting, rather are internal guidelines used by the Oregon Health Authority to determine Medicaid coverage for out-of-hospital births. Consideration needs to be given to the DEM regulations that are written specifically for childbirth in the OOH setting, based on evidence and in settings that are less equipped than a birth center to handle complexities. A client should be trusted to have a conversation with her provider and decide on setting.
- Staff responded that the state is not interfering with access to OOH birth but must follow the statutory provision of primarily low risk births in a birthing center and consider the safety of the client when amending and adopting rules.
- RAC member stated that baby outcomes from labors that begin naturally have different statistical outcomes at 36 weeks than inducing at 36 weeks.
- RAC member indicated that based on evidence reviewed for OOH births, taking into consideration regular fetal surveillance studies, spontaneous onset of labor between 36-37 weeks, and between 42-43 weeks does not show an increased risk. RAC member volunteered to pull together the evidence to share with the RAC.
- Staff noted that given the information shared and potential evidence for specific gestational ages, it was recommended that the polling for this risk factor be delayed.
- RAC member expressed appreciation for the comments made and supported recommendation to delay the poll for this risk factor. RAC member noted the AABC standard for gestational age is 36 weeks to 42 weeks.
- Staff from the Health Licensing Office offered to share literature that was presented to the Board of Direct Entry Midwifery for rulemaking in 2016 and 2019 and will forward to staff.

Poll Question: *Polling for this risk factor has been delayed in order to review literature described by RAC members.*

Fetal: Intrauterine growth restriction (fetal weight < 5th percentile using ethnically appropriate growth tables, or concerning reduced growth velocity on ultrasound)

Discussion:

- RAC member inquired what weight is being reflected with this risk factor. Another RAC member responded that the weight would depend on the actual gestational age so that is why an actual weight is not reflected.

- Concern was registered by RAC member that basing information only on an ultrasound does not take into consideration the person's ethnicity and as such the verbiage should reflect 'and' not 'or.'
- Staff noted that in administrative rule, "or", means the same thing as 'and/or.' Whereas when using the term 'and,' both conditions must be met. The agency is unable to use 'and/or' in rule.
- RAC member stated that the rules need to be understandable to practitioners and stating 'and/or' would be preferable. Staff responded that even if the term 'and/or' could be used, it is interpreted to mean that only one of the two qualifiers needs to be met. If both conditions need to be met, then the agency would use the term 'and.'
- RAC member concurred with changing the term to 'and.' It was noted that based on a person's ethnicity, some babies in a low percentile are normal and healthy. If the goal is to require both conditions, then and/or would not be appropriate based on how it would be interpreted.
- RAC member concurred that both conditions should be met, not just one or the other. Additionally, it was suggested that the risk factor be moved to consultation. There a lot of tiny families that have tiny babies that are completely healthy and to risk them out would affect access to care. It was suggested that ethnically appropriate growth tables do not adequately account for small stature families.
- RAC member concurred with suggestion that this risk factor be moved to consultation.

<u>Poll Question: Keep intrauterine growth restriction as an absolute risk factor with the requirement that both ethnically appropriate growth tables and velocity on ultrasound be considered?</u>

- 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.
  - 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.
  - 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.
  - 45% - 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 Question: Move intrauterine growth restriction to consultation with the requirement that both ethnically appropriate growth tables and velocity on ultrasound be considered?</u>

- 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.

Fetal: Molar pregnancy

Discussion:

- RAC members did not have any comments.

Poll Question: Keep molar pregnancy as an absolute risk factor.

- Results:
  - 92% - 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.
  - 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: Multiple gestation

Discussion:

- RAC member stated that her birth center can't perform multiple gestations because of the CABC requirement; however, other birth centers can and licensed midwives at home can. It was noted that allowing multiple gestations at a birth center may be a closer transport to a hospital then when a client is planning birth with multiples at home.
- RAC concurred with previous comment. Multiple gestation births are occurring all around by providers licensed to do so except at birth centers. The twin birth restriction does not make sense given the birth center is already set up and prepared to handle.
- RAC member suggested moving to a consultation since it is within the scope of practice of providers that work in a birth center. Clients' under a provider's care should be given the option of utilizing the entire scope of that provider's license. Birth centers are closer to hospitals and as such the client's safety would be enhanced for those clients that live further out.
- Staff from Health Licensing Office noted that multiple gestation was very controversial during the DEM rulemaking, and the types of twins were separated out as follows:
  - Required to transfer - monochorionic, monoamniotic twins.
  - Required for consultation – dichorionic, diamniotic twins; monochorionic, diamniotic twins.
- RAC member remarked that prior to the multiple birth restriction, there were no adverse outcomes in her birth center relating to twin births and concurred with moving to consultation;
- RAC member stated that AABC criteria includes singleton pregnancy and dicephalic presentation; however, the AABC does not support choice restrictions or restriction on informed decision making. Concurred with recommendation to move to consultation as there may be extenuating circumstances. Birth centers are generally much closer to hospitals and women will choose a home birth if they cannot birth at a birth center.
- RAC member remarked where is the line drawn or where is twin birth in the spectrum of risk? Compared to singleton births, twin births are at higher risk, but the question becomes how do you weigh the potentially slightly increased risk for having a twin birth in a birth center versus a woman's right to choose the circumstances of her birth.

- RAC member expressed concern with requiring a consult with a doctor that has no experience with birthing twins. It was recommended to separate out the types of twins, aligning with the DEM rules, and identifying what risk factors may apply to each of those. Staff responded that the idea is to consult with someone who has experience in delivering twins. It was noted that the expectation for consultation has been broadened and will be discussed during review of the action items.
- RAC member stated that it is important for a birth center to continue to provide prenatal care even if a hospital birth is planned due to multiples.

Poll Question: *Polling for this risk factor has been delayed in order to review literature and consider DEM rules described by RAC members.*

Fetal: Non-cephalic fetal presentation

Discussion:

- Staff remarked that more data and information may be needed to further discuss and suggested that RAC members share what data or other information is needed to discuss.
- RAC member suggested that the verbiage needs to be changed to indicate that a surprise breech where birth is imminent can be performed at a birth center. Staff noted that for any of the risk factors, if birth is imminent and risk for transferring is higher, then the birth center should follow-through with the birth.
- RAC member stated it would be helpful to have data relevant to the risk factors for both planned cesarean and physiological birth for women with risk factors. It would be helpful to have data on the number of Oregon hospitals that offer physiological birth for both breech and twins, and the provider types that maintain the skills to safely deliver twins and breech babies vaginally. The Oregon Association of Birth Centers could gather some of this data.
- RAC member indicated that she will send an article to M. Bernal on the risks, values and decision making surrounding pregnancy, published in the OB/GYN Journal, that provides good support for the point that it's not the providers' obligation to eliminate risk but to help patients weigh risks, benefits and potential harm informed by scientific evidence and guided by patient-centered ethics.

Poll Question: *Polling for this risk factor has been delayed in order to review literature and consider DEM rules described by RAC members.*

Risk factor discussion concluded.

Action Items from Previous RAC Meetings

A table was shared summarizing the action item requests from previous meetings and the Authority's responses to those actions and proposed rule edits. RAC members were asked to consider the change and provide only new comments or new information.

M. Bernal reviewed the following actions:

OAR 333-077-0010 – Definitions

Certified Nurse Midwife definition was not changed as requested given discussion with Oregon State Board of Nursing and legislation that passed in 2019. The definition was changed to reflect the following:

- *Certified nurse midwife means a registered nurse who is licensed under ORS chapter 678 as a nurse practitioner specializing in nurse midwifery.*

Direct Entry Midwife was amended as requested at the May 2019 meeting:

- *Licensed direct entry midwife means a person licensed under ORS 687.405 to 687.495.*

Physician was amended as requested at the May 2019 meeting. In addition, since chiropractic physicians are included as a provider type on the Oregon Health Plan, Out-of-Hospital Birth Guide, chiropractic physician was included in the definition.

- *Physician means:*
  A person licensed as a doctor of medicine or osteopathy under ORS chapter 677;
  A person licensed as a naturopathic physician under OARS chapter 685, and who has obtained a certificate of special competency in natural childbirth in accordance with OAR 850-035-0230; and
  A person licensed as a chiropractic physician under ORS chapter 684 and who has obtained a certificate of special competency in natural childbirth in accordance with ORA 811-015-0030.

RAC member suggested that the definition of DEM be amended to reference a certified professional midwife (CPM) instead of 'person.' It was noted that not all CPMs are licensed DEMs. Definitions align with statutory language.

Discharge was amended for clarity as requested at the May 2019 meeting.

- *Discharge means:*
  The release or transfer of a client or newborn who was a client of a birthing center to home;
  The transfer of a client or newborn to another health care facility; or
  A client or newborn who has died.

Freestanding Birthing Center was not changed as requested. The definition will continue to align with statute that specifies that a birthing center is licensed for the primary purpose of performing low risk deliveries.

OAR 333-077-0050 – Complaints
OAR 333-077-0055 – Investigations

RAC members had requested in May and July 2019 to add additional clarification in the complaint and investigation rule to identify the complaint triage process. The Authority will not make any changes to these rules. Complaint reviews and investigations are a matter of standard operating procedures for specific allegations of non-compliance. The Authority has jurisdiction to investigate matters relating to non-compliance with the birthing center administrative rules and relevant statutes. Sharing information pertaining to complaints and investigations is better suited in FAQs that can be obtained from the website or in conversations with staff versus formal language in rule. All matters relating to complaints against specific provider types are referred to the appropriate health professional licensing board.

It was further noted that these rules align with other facility types.

OAR 333-077-0070 – Governing Body Responsibility

Section (2) of this rule was revised as requested at the May 2019 meeting. While the original language was based on requirements in statute for all health care facilities, it is understood that physicians are not common providers in birthing centers and as such corrections are necessary. Practitioner terms were updated to align with the Commission for the Accreditation of Birth Centers (CABC) and include 'clinical provider' and 'clinical staff.' CABC definitions for these terms were provided for reference and staff asked RAC members to consider whether the definitions are appropriate in order to add to the definitions section (OAR 333-077-0010).

- *(2) The governing body shall:*
  (a) Establish in writing: …
  (D) Required training for all employees and clinical providers with privileges that includes, but is not limited to…
  (c) Ensure that all clinical staff for whom state licenses are required are currently licensed, certified or registered;
  (d) Ensure that all clinical providers health care personnel admitted to practice in the facility are granted privileges consistent with their individual training, experience and other qualifications;
  (e) Ensure that procedures for granting, restricting and terminating privileges of all clinical providers exist, and that such procedures are reviewed on a regular basis; …
- *(3) All clinical providers admitted to practice in the birthing center shall effectively review the professional practices of the birthing center for purposes of reducing morbidity and mortality and for improving client care.*

RAC member inquired what the process would look like if a birth center was full but had additional midwives available to assist but at a neighboring birth center. Staff noted that birth centers should have written agreements in place in this scenario and that the midwife would have to be credentialed at the birth center where birth would take place. RAC member suggested that this rarely occurs, and it would not be feasible to have all midwives credentialed at all possible birth centers. Staff noted that the requirement is in statute and thus must be adhered to. It was further noted that a midwife would be operating under the license of the other birth center and must follow the policies and procedures of that birth center, not the policies and procedures of the center where the midwife is primarily located.

RAC member further inquired about other staffing scenarios. Staff indicated that discussions about specific scenarios should be discussed outside of the RAC meeting and could be included in an FAQ document.

OAR 333-077-0080 – Personnel

The Authority was asked at the May and July 2019 to reconsider staffing requirements and ensure that language does not conflict with the nurse practices act. Section (1) of the rule was changed to:

- *A birthing center shall, at a minimum:*
  (a) Maintain a sufficient number of clinical staff on duty and on call to provide effective client care and all other related services, and to ensure that no client in active labor shall remain unattended;
  (b) Have one clinical staff person trained in the use of emergency equipment and certified in neonatal resuscitation endorsed by the American Academy of Pediatrics, on duty at all times a client is present;
  (c) Have one clinical provider present at each birth. A second clinical staff person trained in the use of emergency equipment and certified in neonatal resuscitation, endorsed by the American Academy of Pediatrics skills shall be present during each birth;

(d) Ensure all clinical staff providing direct client care hold a current American Heart Association Basic Life Support (BLS) Provider or equivalent CPR course completion document (the course must include a practical skills evaluation);
(e) Ensure that employees, contractors and volunteers receive appropriate orientation including orientation to written policies and procedures;
(f) Have a job description for each position that delineates the qualifications, duties, authority and responsibilities inherent in each position;
(g) Conduct an annual work performance evaluation for each employee; and
(h) Create an annual continuing education plan for its employees.

OAR 333-077-0090 – Policies and Procedures

At the July 2019 meeting, it was requested that the term 'Certified Nurse Midwife' be changed throughout the rule to 'licensed nurse midwife.' As discussed above under 0010 – Definitions, the term will remain the same.

Section (2) was revised as suggested at the July 2019 meeting by removing the reference to nurse practitioner and certified professional midwife. Section (2) of the rule was changed to:

(2) The client care and services of each birthing center shall be under the supervision of a manager who shall be a licensed direct entry midwife, certified nurse midwife, or physician.

RAC member suggested that a Certified Professional Midwife be added back. While they may no longer be a licensed DEM and attending births, they would still have the experience necessary to oversee and run a birthing center.

Staff from Board of DEM noted that for purposes of this rule, the issue is around supervising client care and client services not the operation of the center. It was questioned whether an unlicensed provider can supervise client care or services in a birth center.

RAC member suggested that a traditional midwife who is not a licensed midwife cannot attend a birth in an Oregon birthing center.

ACTION – Based on feedback provided, staff will look further at statutes and existing rule and report back.

Under section (3), staff noted that an additional amendment was made based on requirements in ORS 433.017 that require physicians, naturopaths and nurse practitioners that attend a pregnant woman to take or cause to be taken a sample of blood for tests related to infectious conditions.

- *(3) A birthing center shall develop and implement written policies and procedures that include, but are not limited to, the following…*
  (n) Performance of appropriate laboratory services including tests required pursuant to ORS 433.107 and the rules adopted thereunder.

Relating to blood draws, RAC member inquired whether the language clarifies that a "CPM" can draw blood. Additionally, it was questioned whether this would require a COVID test and whether a woman could decline a COVID test.

Staff from Board of DEM noted that nothing in the language would appear to preclude a licensed DEM from drawing blood. PHD staff noted that OAR 333-019-0036 specifies that routine tests shall include syphilis, hepatitis B and HIV and does not specify COVID. PHD staff will inquire with Acute and

Communicable Disease program to determine whether future changes to include COVID are being considered.

The action items to consider language that clarifies that a birth center may provide prenatal care regardless of whether the client is eligible to deliver at a birthing center and to consider making consultation more flexible so that a birthing center can consult with other clinicals specialists will be discussed under new rule OAR 333-077-0125 - 'Assessment of Risk Status and Consultation Requirements.'

ACTION – Staff will seek input from legal counsel regarding the statutory provisions relating to provider types and blood draws. Staff will also inquire with the Acute and Communicable Disease Program whether they are considering adding COVID testing to OAR 333-019-0036.

OAR 333-077-0100 – Client Care Services

Section (2) was revised as suggested at the July 2019 meeting. Section (2) of this rule was changed to:

- *(2) Each client shall sign, and receive a copy of, a client disclosure form which includes, but is not limited to, the following information:*
  (a) Services provided to client and newborn;
  (b) Risks, benefits and eligibility requirements;
  (c) Responsibilities of the client and family members or legal representatives;
  (d) Fees for services including financial arrangements;
  (e) Malpractice coverage or professional liability coverage;
  (f) Risk assessment, consultation and transfer requirements;
  (g) Emergency care and transport plan in the event of complications to the client or newborn; and
  (h) Identity and qualifications of clinical staff.

Subsection (3)(b) was revised as suggested at the July 2019 meeting. Section (3) of this rule was changed to:

- *(3) The statement of client rights shall include, but is not limited to, the following:*
  (b) Clients shall be offered services without discrimination as to race, ethnicity, color, religion, gender identification, sexual orientation, national origin or source of payment;

Subsection (4)(b) and (c) were revised to reference new rule OAR 333-077-0125 as follows:

- *(4) A birthing center shall: …*
  (b) Assess the client's risk status throughout pregnancy, labor and delivery in accordance with OAR 333-077-0125 to determine if out-of-hospital birth is appropriate.
  (c) Consult with a provider of maternity care who is credentialed to admit and manage responsibilities in a hospital, or other specialty provider, in accordance with OAR 333-077-0125…

RAC member inquired whether the committee will be able to see a full version of the rules in a tracked changes format. Staff responded yes.

Section (5) was revised as suggested at the July 2019 meeting by removing references to specific tests. Section (5) has been amended as follows:

- *(5) A birthing center that provides **prenatal care** shall perform regular, periodic prenatal exams and assessments of client and fetus risk status. A prenatal exam shall include at a minimum:*
  (a) Physical exam;
  (b) Urinalysis and other laboratory screenings as determined necessary by the clinical provider;
  (c) Discussions about the client's health and newborn's health including good nutrition and how to reduce pregnancy complications and newborn's risk for complications;
  (d) Fetal health assessment; and
  (e) In third trimester, discussions about preparing for childbirth and classes available;

RAC member inquired whether the reference to "physical exam" might conflict with telehealth services that are currently being performed due to COVID-19. Staff noted that the program is currently reviewing all facility types and where accommodations can be made in terms of regulatory expectations.

ACTION – Staff will consider further whether additional language is needed to allow for telehealth options given the current pandemic.

Section (6) was revised based on comments emailed by a RAC member after the July 2019 meeting. Section (6) is amended as follows:

- *(6) **Intrapartum care** provided by a birthing center shall include, but is not limited to:*
  (a) Periodic assessment of the client's physical health and emotional and psychological needs including but not limited to:
  (A) Monitoring of vital signs;
  (B) Urinalysis if indicated;
  (C) Pain assessment; and
  (D) Frequency of contractions.
  (b) Periodic assessment of the fetus's health including but not limited to:
  (A) Monitoring fetal heart rate and fetal movement; and
  (B) Abdomen palpation to determine fetal lie and presentation;
  (c) Comfort measures including but not limited to:
  (A) Physical assistance;
  (B) Emotional support; and
  (C) Pain relief methods; and
  (d) Companionship during labor and childbirth with a client's companion of choice.

Section (7) was revised as suggested at the July 2019 meeting. Section (7) is amended as follows as follows:

- *(7) **Postpartum care** shall consist of periodic assessment of the client's health and newborn's health.*
  (a) The client health assessment includes but is not limited to:
  (A) Physical exam;
  (B) Laboratory screening tests, if applicable;
  (C) Education in child care including breastfeeding, immunization, and referral to sources of pediatric care;
  (D) Provision of or referral to family planning services; and
  (E) Referral to newborn screenings as required in OAR 333-077-0170 if screenings are not provided by the birthing center.

(b) The newborn health assessment includes but is not limited to:
(A) Physical exam;
(B) Laboratory screening tests, if applicable; and
(C) Screenings for newborns in accordance with OAR 333-077-0170.

NEXT STEPS
M. Bernal asked RAC members to watch for e-mail with meeting poll request. For the immediate future, all meetings will be conducted remotely only.