

HERC Coverage Guidance – Out-of-hospital (OOH) Birth Disposition of Public Comments

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Commenters

Identification	Stakeholder
A	OB-Gyn physician <i>[Submitted December 3, 2014]</i>
B	CPM, LDM <i>[Submitted November 18, 2014]</i>
C	CPM, LDM <i>[Submitted November 18, 2014]</i>
D	QHOC Medical Directors <i>[Submitted December 9, 2014]</i>
E	Health plan medical director <i>[Submitted Dec. 10, 2014]</i>
F	Oregon Midwifery Council <i>[Submitted Dec. 10, 2014]</i>
G	Health Plan Midwife Committee Chairman <i>[Submitted Dec. 10, 2014]</i>
H	Oregon Pediatric Society, Doernbecher Children’s Hospital, OHSU, Portland, OR <i>[Submitted Dec. 12, 2014]</i>
I	LDM <i>[Submitted December 15, 2014]</i>
J	MD, Retired Ob/Gyn <i>[Submitted December 15, 2014]</i>
K	RN <i>[Submitted December 15, 2014]</i>
L	Epidemiologist and RN <i>[Submitted December 15, 2014]</i>
M	Community Health Plan <i>[Submitted December 15, 2014]</i>

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Public Comments

ID	#	Comment	Disposition	High-Risk Table Line
A	1	Two items to consider: 36 weeks' gestation is technically preterm birth, not sure a great idea for preterm births to happen at home, so consider using \geq 37 weeks.	Box language has been clarified to emphasize greater than 36 and less than 41 completed weeks of pregnancy, which would encompass EGA 37 weeks 0 days through 41 weeks 6 days, consistent with NICE guidance. Preterm is also a transfer requirement in the coverage guidance so aligning these to be 37 weeks 0 days would be appropriate.	1
	2	I don't see either pre-gestational or gestational diabetes on your pregnancy complications list. Certainly both put moms and babies at higher risk than genital herpes.	Diabetes (uncontrolled gestational, gestational requiring medication, or pre-existing Type I or Type II) has been added to the list of high-risk coverage exclusion criteria for planned out-of-hospital birth; diet-controlled gestational diabetes has been added to the list of criteria for consultation prior to planned out-of-hospital birth.	5
B	1	I am a licensed midwife, practicing in Portland Oregon in a blended licensed midwife/nurse-midwife practice. We offer prenatal care, home birth and postpartum services to low risk women and strongly desire to include low income women in our client base. However, I am concerned that the proposed coverage guidelines for out of hospital birth is NOT based on quality research in terms of what constitutes low risk. I am requesting that your committee review the evidence on low risk (see below) and reissue your guidelines based on unbiased, research.	Commenter does not specify which criteria she disagrees with. EbGS does not believe their evidence sources are biased or poor quality.	NA
B	2	Making normal birth a reality: Consensus statement from the Maternity Care Working Party http://mothersnaturally.org/pdfs/UKNormalBirthDocument.pdf	This is a consensus statement on the definition of a normal birth. They define normal birth as the following: <ul style="list-style-type: none"> • women whose labor starts spontaneously, progresses spontaneously without drugs, and who give birth spontaneously; • women who experience any of the following provided they do not meet the exclusion criteria: <ul style="list-style-type: none"> ○ augmentation of labour 	NA

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			<ul style="list-style-type: none"> ○ artificial rupture of membranes (ARM) if not part of medical induction of labor ○ Entonox ○ Opioids ○ Electronic fetal monitoring ○ Managed third stage of labor ○ Antenatal, delivery or postnatal complications (including for example post partum hemorrhage, perineal tear, repair of perineal trauma, admission to SCBU or NICU) <p>Normal delivery excludes:</p> <ul style="list-style-type: none"> ● induction of labor (with prostaglandins, oxytocics or ARM) ● epidural or spinal ● general anaesthetic ● forceps or ventouse ● cesarean section ● episiotomy <p>While a list of references is provided, supporting evidence is not specifically discussed.</p>	
B	3	http://www.bmj.com/content/330/7505/1416.full?ehom=	Duplicate of the above document.	NA
B	4	Citizens for Midwifery Resources Webpage http://cfmidwifery.org/resources/	Website states that Citizens for Midwifery are “a non-profit, volunteer, grassroots organization. Founded by several mothers in 1996, it is the only national consumer-based group promoting the Midwives Model of Care.” No evidence specifically identified.	NA

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C	1	<p>I heard that the HERC is currently taking public comment on what constitutes low-risk for out of hospital birth. I have read the draft recommendations and am concerned about the proposed recommendations because they appear to risk women out for a large number of things that midwives are trained and qualified to handle.</p> <p>This is important to me because I am both a home birth midwife and a mother who has (safe, successful) had out of hospital births. I am concerned because I've known women who have chosen to have unassisted births because of similar strict sets of risk criteria. There are many women, who, when denied coverage due to unreasonable risk factors, will refuse to go to a hospital and will then be exposed to greater risks because of a lack of provider at their birth.</p>	<p>EbGS bases its decisions on the balance of benefits and harms according to the best available evidence, while taking into account patient values and preferences and limited resources. We understand that women have strong and highly variable preferences and that this report is a coverage guidance, which defines when home birth should be reimbursed as a safe and effective service.</p> <p>The coverage recommendation language now distinguishes between complications requiring consultation and those which require transfer or planned hospital birth, recognizing that some conditions require a planned hospital birth or transfer of care, while other risk factors require consultation to evaluate an individual situation and inform the patient's decision and provider's recommendation about where to plan to have her baby.</p>	NA
C	2	<p>Oregon's licensed midwives and birth centers both have sets of reasonable risk criteria that could be used to define coverage for out of hospital birth. The Midwives Association of Washington State also has a well-researched set of risk criteria that could be used in this situation (http://www.washingtonmidwives.org/documents/MAWS-indications-4.24.08.pdf). Please consider using these pre-existing sets of criteria when you consider who to offer coverage to.</p>	<p>Oregon birth center risk criteria are included in the guidance document as Appendix A. No reference provided for Oregon licensed midwives risk criteria. Washington criteria are provided in Appendix 1 of this document. They are similar to the other risk criteria already included. Commenter does not identify which of the proposed criteria she disagrees with.</p>	NA
D	1	<p>The possibility of VBAC is concerning given that many hospitals, especially in rural areas, cannot even offer VBAC. It would not be acceptable for these hospitals to be back up. And it is concerning that a condition that is too high risk for a hospital would be acceptable to be done at home.</p>	<p>Box language already indicated that women with prior Cesarean are not considered low-risk (and thus not candidates for out-of-hospital birth). The coverage recommendation has been modified to clarify the requirement for risk assessment at intake, during prenatal care and during labor and specify high-risk coverage exclusion criteria, consultation criteria and transfer criteria.</p>	3

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D	2	Teen pregnancy is also a higher risk condition	Guidelines from British Columbia specify age less than 17 or over 40 as indication for discussion, and age less than 14 as criterion for consultation. EbGS decided to strike these recommended criteria for consultation based on lack of evidence that age in and of itself is a criterion necessitating consultation in the absence of other factors.	7
E	1	<p>Should any of the complications occur at any point in the pregnancy, there should be a re-evaluation to determine the risk/status level;</p> <ul style="list-style-type: none"> a. Low risk criteria should include an ultrasound between 12 – 30 weeks (standard accepted practice); b. Low risk criteria should include maternal and paternal age parameters such as 18 – 45 years of age; 	<p>HERC’s existing coverage guidance on Ultrasound in Pregnancy reports the following:</p> <p>“Routine US in early pregnancy (< 24 weeks) does not change patient management, substantially alter delivery modes, or improve health outcomes, at least not in high-resource settings.” and</p> <p>“Evidence has not shown routine US in late pregnancy (> 24 weeks) to change patient management, affect delivery mode, or improve health outcomes.” Not added to low-risk criteria based on previous evidence review finding no change in management of pregnancy based on routine ultrasound.</p> <p>Regarding age, see comment D2 and disposition.</p> <p>Our evidence sources make no mention of paternal age as a risk factor for planned home birth.</p> <p>Women with inadequate prenatal care face increased risk regardless of birth setting, so this by itself should not exclude out of hospital birth as an option. EbGS decided that unknown HIV or HBV status should warrant a planned hospital birth, as early interventions could make a difference to the newborn.</p> <p>Coverage recommendation has been updated to require risk assessment throughout prenatal and labor period.</p>	<p>4</p> <p>7</p> <p>15</p>

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ID	#	Comment	Disposition	High-Risk Table Line
E	2	<ul style="list-style-type: none"> a. Complications should include having had an IUD in place; b. Complications should include third degree lacerations as well as fourth degree lacerations; c. Complications should include fractured clavicle and shoulder dystocia; d. Complications should include parental Jehovah’s Witness status – due to inability to transfuse; e. Complications should include history of large babies (>9 pounds); f. Complications should include ‘incomplete prenatal testing’ such as strep and all STDs g. Complications should include VBACs (we agree with Cascade CCO); and h. Complications should include severe mental health issues not well controlled or addressed; 	<p>a. There is no evidence supporting history of IUD use as a high-risk condition in pregnancy. “Status following removal of the IUD” is Category A in the Netherlands guidelines.</p> <p>b. History of third or fourth--degree laceration in a prior delivery is listed as a criterion for consultation. History of fourth-degree laceration is listed as a criterion for consultation or planned hospital birth depending on whether functional recovery has been achieved (following Netherlands). For laceration requiring hospital repair, see comment F24. Intrapartum third- or fourth-degree laceration requires transfer, unless it is a third-degree laceration not requiring hospital repair, (which is an indication for consultation).</p> <p>c. Shoulder dystocia with or without fetal clavicular fracture in a previous pregnancy is a criterion for consultation. EbGS discussed that definition is challenging and ultimately determined that consultation should be obtained to elicit specific circumstances & severity, and determine likelihood of recurrence.</p> <p>d. No evidence is presented by commenter on Jehovah’s Witness status. All women giving birth out of hospital should have a full informed consent procedure, including information about what would be done if transfusion is indicated but declined. Personal or cultural objection to transfusion is not found as risk exclusion criterion in other systems identified.</p> <p>e. NICE recommends consultation if a prior baby was > 4.5 kg; this appears in our recommendation.</p> <p>f. Inadequate prenatal care is listed as a criterion for consultation. However, because of the risk to the baby, unknown HIV or HBV status is a high-risk coverage exclusion criterion.</p> <p>g. Absence of prior cesarean or other hysterotomy is a minimum criterion for low-risk pregnancy</p>	<p>4</p> <p>8, 9</p> <p>10</p> <p>11</p> <p>13</p> <p>15</p> <p>3</p>

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			<p>h. Drug or alcohol use with high risk for adverse effects to fetal or maternal health requires hospital birth</p> <p>Maternal mental illness under outpatient psychiatric care has been added to coverage guidance as requiring consultation prior to planned out-of-hospital birth, consistent with NICE guidance in table 9. Maternal psychiatric illness requiring inpatient care is added as a high-risk coverage exclusion criterion, again consistent with NICE guidance (table 6).</p>	46
E	3	I thought there was criteria regarding specific distance requirements from a hospital that could perform resuscitative procedures and emergency C-sections.	No such requirement was identified in any of the sources used to generate the risk criteria; EbGS declines to make coverage recommendation based on distance.	NA
F	1	I am writing on behalf of the Oregon Midwifery Council, which represents Direct-Entry Midwives in Oregon, to express my serious concern about the Draft Coverage Guidance on Planned Home Birth. Firstly, I am concerned that the HERC makes only a weak recommendation for the coverage of planned home birth for low risk pregnancies when the evidence is strong that planned home birth with a trained midwife in low risk pregnancies is a safe option for women and babies.	Thank you for your comment. “Weak recommendation” is a language that comes from the GRADE system and indicates the degree of confidence for a recommendation (see HERC methodology for details.) In this case, because of the potential for bias in the observational studies, the subcommittee elected to make a weak recommendation for coverage of planned out-of-hospital birth.	NA
F	2	Secondly, many items on the “High Risk Conditions” list are completely out of line with the research on the safety of planned home birth with midwives. The list is much longer than is appropriate for coverage guidance for a provider type that is both skilled at, and required by OAR to use, risk assessment, consultation, referral, and transfer of care as needed. The current draft “high risk” list would prevent many healthy pregnant women from accessing basic maternity care with the provider type and at the location of their choice.	<p>The list of “high risk exclusion criteria” was compiled from the trusted sources utilized by the EbGS – the Netherlands, British Columbia, and Ontario guidances as well as the Oregon Birth Center absolute risk criteria.</p> <p>There are situations in which consultation is indicated to address appropriateness for home birth, but transfer to a hospital setting may not be required.</p> <p>The recommendation has been clarified to specify which conditions are high-risk coverage exclusion criteria, criteria for consultation, or criteria for transfer to hospital care. For some consultation criteria, coverage for out of hospital birth may still be</p>	NA

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			recommended. See revised coverage recommendation language.	
F	3	<p>The HERC itself identifies the Cochrane Review and the Guidelines on the Care of Healthy Women and Their Babies During Childbirth of the National Institute for Clinical Excellence as its only two trusted sources in its review of the evidence on planned home birth yet somehow arrives at a different conclusion than either of these sources. The Cochrane Review states clearly that there is no evidence to favor planned hospital or planned home birth for low risk women. In fact the review states,</p> <p style="padding-left: 40px;">It seems increasingly clear that impatience and easy access to many medical procedures at hospital may lead to increased levels of intervention which in turn may lead to new interventions and finally to unnecessary complications. In a planned home birth assisted by an experienced midwife with collaborative medical back up in case transfer should be necessary these drawbacks are avoided while the benefit of access to medical intervention when needed is maintained. Increasingly better observational studies suggest that planned hospital birth is not any safer than planned home birth assisted by an experienced midwife with collaborative medical back up, but may lead to more interventions and more complications. (Olsen, Clausen 2012).</p>	<p>This information is correct, quoted from the Plain Language Summary in the Cochrane review (p. 2).</p> <p>The NICE guideline review does review other studies beyond the Cochrane review in making its recommendation as well.</p> <p>This coverage guidance does not favor either planned hospital birth or planned out-of-hospital birth for low risk women. Rather, the coverage guidance recommends that out-of-hospital birth be covered under health plans as a safe and effective option for low risk women, and defines indications which may put a woman and her baby at risk for poor outcomes in a planned or actual out-of-hospital birth based on a review of high-risk criteria from other internationally-recognized bodies.</p>	NA
F	4	<p>Additionally, the NICE guidelines explicitly state that, for low-risk women, out-of-hospital birth is “particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit (National Institute for Clinical Excellence 2014).” The HERC is charged with making an evidence based recommendation and it must remedy this significant departure from that obligation.</p>	<p>This information is correct. See comment F3 above.</p>	NA

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F	5	<p>While the HERC has identified a number of fully recognized, research based-risks for home birth such as multiple gestation, non-vertex presentation, and pre-existing disease in the mother that negatively impacts pregnancy outcomes (e.g. chronic hypertension), it has also included potential risk factors that are either not based in research or are absolutely not appropriate for inclusion in coverage guidance. Coverage guidance should be based on risks that can be identified at the start of care or upon reassessment at term. It is inappropriate to include emergency occurrences that the midwife could not have foreseen. If these occur, is this guidance asserting that the midwife should not be compensated for all care before and after the event?</p>	<p>This coverage guidance recommends coverage for out-of-hospital birth for women with low risk pregnancies.</p> <p>See comment F2.</p>	NA
F	6	<p>In addition, there are far too many risk factors included in this guidance that are outside of accepted guidelines in the US, Canada, and the UK (health systems with which we normally compare ourselves). The HERC Coverage Guidance on Planned Home Birth should only include those risk factors in the “High Risk” list that are based in high-quality evidence and are in common usage in comparable health systems that have good outcomes from out-of-hospital midwifery care such as Canada and the UK.</p>	<p>The risk factors included in this coverage guidance are all derived directly from the guidelines listed by the commenter. That said, systems of midwifery care in Canada and the UK are sufficiently distinct from those in the US as to make direct translation impractical. Not all conditions that are amenable to out-of-hospital management in those systems are appropriate for such in the US.</p> <p>See comment F2.</p>	NA
F	7	<p>Further, when the HERC creates such a lengthy list of “high risk” conditions (beyond those included in a basic absolute risk guideline) that would exclude a patient from coverage for home birth it circumvents the rights of low-income patients to make informed choices about their own health care. This draft “high risk” list is not equivalent to recommending against payment for an experimental or medically unnecessary surgery, it is actually a recommendation against coverage for basic maternity and newborn care for many healthy women experiencing normal pregnancies. Consider, for example, that a woman with a history of genital herpes with no outbreak in the past two years, who has hyperemesis until 14 weeks, but is able to gain weight normally, and has a brother with down syndrome is “risked” out three times even though she is a perfectly reasonable candidate for home birth as long as she does not have a herpes outbreak at the time of birth.</p>	<p>See comment F2.</p>	NA

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F	8	There are a number of items that should be removed from the draft “High-Risk” list as they are not research-based and are not included in the high-risk or exclusion criteria from the 2014 Guidelines on the Care of Healthy Women and Their Babies During Childbirth of the National Institute for Clinical Excellence, The Indications for Discussion, Consultation, and Transfer of Care from the College of Midwives of British Columbia, or the Consultation and Transfer of Care Guidelines of the College of Midwives of Ontario, the three main Guidelines that the HERC has reviewed. Many of these items are absolutely appropriate for evaluation and consultation, but to exclude them from coverage is nonsensical because without the evaluation or consultation process we can’t know if significant risk is found in that particular case.	See comment F2.	NA
F	9	<p>The following items should be removed from the “High Risk” list for the above-stated reasons:</p> <p>Pregnancy past 41 weeks (The NICE guidelines specifically include pregnancy to 41+6 weeks)</p> <p>History of preterm birth</p> <p>History of fourth degree laceration</p> <p>History of more than three first trimester spontaneous abortions, or more than one second trimester spontaneous abortion</p> <p>Failure to progress/ failure of head to engage in active labor</p> <p>Cervical dysplasia requiring evaluation</p> <p>Hyperemesis gravidarum</p> <p>Family history of genetic/ heritable disorders</p> <p>Age < 14</p>	<p>See comment F2 as well as comments about specific criteria below.</p> <p>The risk factor for post-term pregnancy has been clarified to define low risk as than 41 completed weeks (that is, the cutoff is > 41 weeks, 6 days.)</p> <p>Our recommendation includes history of preterm birth as an criterion for consultation, following the Netherlands guidance, which rates it as category B (consultation)</p> <p>History of 4th-deg laceration is listed by Netherlands guidance as category A or C, depending on whether satisfactory function is restored. After discussion, EbGS recommends consultation when there is a history of third- or fourth-degree laceration in prior pregnancy. The recommendation has been clarified that without functional recovery requires hospital birth, with functional recovery requires consultation.</p> <p>Box language on history of abortions is taken from the Ontario guidance (consultation recommended)</p> <p>Failure to progress/engage is taken from the Oregon birth center</p>	<p>2</p> <p>18</p> <p>9</p> <p>19</p> <p>20</p>

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			<p>ARC. Both the Ontario and Netherlands guidance recommend it as a criterion for consultation. EbGS decided this should be a criterion for transfer, since that would be the purpose of consult.</p> <p>Cervical dysplasia requiring evaluation is Netherlands category B (consultation)</p> <p>Hyperemesis gravidarum is recommended by Netherlands guidance as requiring a higher level of care until resolved. Language was changed to say “refractory” hyperemesis gravidarum indicates planned hospital birth.</p> <p>Family history of genetic/heritable disorders is taken from the British Columbia guidance as requiring consultation</p> <p>Age < 14: Please see comment D2.</p>	<p>21</p> <p>22</p> <p>23</p> <p>7</p>
F	10	<p>Beyond these, there are a number of items that should either be removed from the high-risk list for a variety of reasons or edited for clarity. I have addressed these items individually below:</p> <p>History of Pre-eclampsia/ HELLP syndrome. Of the three guidelines used in the HERC review, only the NICE guidelines do include history of pre-eclampsia but only if preterm birth was required. We know that risk of pre-eclampsia decreases for multiparas and we know that pre-eclampsia is a very broad diagnosis. While a history of pre-eclampsia may be a significant risk factor it should be further defined or specified if it is going to be included in the high risk list. For instance “HELLP syndrome and/or pre-eclampsia requiring preterm birth.” All patients will be evaluated for signs of pre-eclampsia in each pregnancy which is the more appropriate risk assessment tool in this case.</p>	<p>NICE lists history of pre-eclampsia as necessitating individual assessment (table 8).</p> <p>Pre-eclampsia requiring preterm birth and history of HELLP syndrome in prior pregnancy are high-risk coverage exclusion criteria. Pre-eclampsia not requiring preterm birth is a criterion for consultation prior to planned out of hospital birth. See revised box language.</p>	24
F	11	<p>History of Unexplained stillbirth/neonatal death or previous death related to intrapartum difficulty. This is a broad category that is best suited to careful evaluation, consultation, and informed consent rather than use as a risk for coverage exclusion. There are many cases included in this category that could be</p>	<p>History of unexplained stillbirth is listed in multiple sources (NICE, Netherlands, Ontario, and British Columbia) as requiring consultation.</p>	25

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		completely appropriate for a home birth, for instance a history of an intrapartum demise due to a cord accident should not exclude someone from a subsequent home birth. Additionally a person who had a previous unexplained stillbirth with no other past or current clinical risk factors could be an excellent candidate for home birth with full informed consent about the risks involved and should not face an additional financial hardship as a result of this choice.	<p>NICE guidance does include “Unexplained stillbirth/neonatal death or previous death related to intrapartum difficulty” as a condition indicating planned hospital birth.</p> <p>Both of these are reflected in the updated box language. If unexplained stillbirth/neonatal death or previous death was related to intrapartum difficulty, planned hospital birth is indicated. Otherwise, consultation is indicated.</p>	
F	12	History of postpartum hemorrhage requiring additional treatment or blood transfusion. The research is not clear as to whether history of postpartum hemorrhage is predictive of future postpartum hemorrhage (Prata 2011). If this item is to be included in the high risk list it should be further clarified so that it relates to truly concerning hemorrhages. A woman who had a 500 cc blood loss and received Pitocin for it (“further treatment”) would currently be defined as high risk which is not appropriate. Perhaps it could be worded “Postpartum hemorrhage requiring blood transfusion.”	<p>NICE table 6 lists “primary postpartum hemorrhage requiring <u>additional treatment or blood transfusion</u>” as an indication for birth at an obstetric unit, and specifies “additional pharmacologic treatment or blood transfusion.” As there are a variety of possible scenarios, EbGS decided to make this a condition requiring consultation.</p> <p>The Prata 2011 study cited was a prospective cohort conducted in Egypt with 2510 women experiencing singleton pregnancies. There were 93 cases of primary PPH in the cohort. The authors found that “history of PPH in a previous pregnancy increased the risk of PPH by almost 69 times” (OR 68.61, p<0.001), although this was based on only seven women with a history of PPH, five of whom had repeat PPH and two of whom did not.</p>	26
F	13	History of retained placenta requiring manual removal. This item is concerning because it may exclude many women with histories that are not actually clinically concerning for the current pregnancy. History of retained placenta may or may not be predictive for future complications and the appropriate clinical course of action is ultrasound evaluation for abnormal implantation.	NICE table 6 lists “retained placenta requiring manual removal in theatre” as an indication for birth at an obstetric unit. EbGS accepted expert recommendation to require transfer only if surgical removal was necessary, and consultation for history of manual removal.	27
F	14	History of shoulder dystocia. While a history of shoulder dystocia is a risk factor for future births this is an item that should necessitate careful evaluation of the records and current pregnancy course and consultation to determine whether the risk is significant for the current pregnancy rather than immediate denial of coverage	See comment E2.	10

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		without evaluation. A woman with tightly controlled blood glucose levels in a subsequent pregnancy with a smaller baby is likely, for example, not to experience a repeat complication.		
F	15	History of cesarean section. The two studies that include significant numbers of out-of-hospital vaginal births after cesareans (where the increased risk of rupture from tocolytics is not a factor as they are outside of scope of practice) showed good outcomes for mothers and babies as long as no other significant risk factors (e.g. breech, twins) were present (Cheyney et al 2014, Stapleton et al 2013).	<p>Our recommendation follows NICE table 6, which lists “Caesarean section” as a previous complication indicating birth at an obstetric unit.</p> <p>Stapleton et al 2013 is a retrospective cohort study of 15,574 women receiving care in US birth centers from 2007-2010. There were only 56 TOLACs in this cohort (0.004%), of which 39 (70%) had successful VBAC. Because of the very small sample size, the authors do not separately analyze outcomes by prior cesarean status.</p> <p>Cheney 2014 is a retrospective cohort study of 16,924 women who planned home births in the US between 2004-2010. This cohort included 1054 women with prior cesarean (0.06%), of whom 915 (87%) had successful VBAC. Authors found that TOLAC patients experienced “an increased risk of intrapartum fetal death, when compared to multiparous women with no prior cesarean (2.85/1000 TOLAC vs 0.66/1000 multiparas without a history of cesarean, P = 0.05)” and no increase in neonatal death.</p>	3
F	16	Placenta previa, vasa previa, low lying placenta. This item should specify placenta previa at term as placenta previa in early pregnancy is not relevant and simply requires reevaluation. Low lying placenta should be removed as it is vague, not research-based and is not included in other relevant guidelines	<p>NICE table 7 lists “Placenta praevia” as a complication of current pregnancy indicating birth at an obstetric unit.</p> <p>Oregon birth center absolute risk criteria list “Low-lying placenta within 2 cm or less of cervical os; vasa previa; complete placenta previa” as prohibiting admission to the birth center.</p> <p>Ontario guidelines list vasa previa and asymptomatic placenta previa persistent into third trimester as indications for antenatal consultation, and symptomatic previa as an indication for transfer.</p>	28

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			Coverage guidance has been edited to specify “Low lying placenta within 2 cm or less of cervical os at term; placenta previa, vasa previa” as a high risk exclusion criterion.	
F	17	Confirmed intrauterine death. This is an odd item to include in the high risk list as it is not a risk for the mother unless there are signs of infection or DIC after the passage of significant time. A family who has had a confirmed intrauterine death should have the option to have a home birth covered if they have received informed consent and it is what they want for their care during such a personal and trying process. This is yet another item that should necessitate careful evaluation, consultation, and informed consent but is not a reason for exclusion from coverage.	NICE table 7 lists “Confirmed intrauterine death” as a complication of current pregnancy indicating birth at an obstetric unit. “Dead fetus” is Netherlands C (requiring secondary obstetric care); however, Ontario guidelines list “Intrauterine fetal demise” as an indication for consultation only. Coverage guidance is consistent with the Ontario recommendation, requiring consultation to determine risk.	29
F	18	Body mass index at first prenatal visit of greater than 35 kg/m². BMI on its own is not appropriate for inclusion in the high risk list. Many larger women are excellent candidates for home birth as long as other risk factors, such as uncontrolled gestational diabetes or limited mobility are not present. This is another item for careful evaluation, consultation, and informed consent, not for exclusion from coverage	NICE table 7 lists “BMI at booking > 35 kg/m ² ” as a complication of current pregnancy indicating birth at an obstetric unit; EbGS decided to make it a requirement for consultation as risks are higher for some women and not for others, such as those who have had a number of uncomplicated prior births.	30
F	19	Small for gestational age fetus. This item needs to be clarified so that it does not unnecessarily exclude babies who are small but well within normal limits. The NICE guidelines do include this risk factor but specify that they mean less than 5th percentile. Additionally, if this item is to be included in the high risk list it should be specified that ethnically specific charts should be used so that babies of smaller ethnicities are not erroneously identified.	As noted by commenter, NICE specifies < 5%ile or reduced growth velocity on US as indicating planned hospital birth. Coverage guidance was edited to clarify this, with additional language to specify ethnically-appropriate growth tables.	31 32
F	20	Prelabor rupture of membranes > 24 hours. While the risk of infection does seem to increase somewhat after 24 hours of ruptured membranes that risk is still small, especially in the home birth setting and with minimal vaginal exams and other interventions. This should be a matter for the informed consent of the client within the OARs and practice standards of the provider.	Our recommendation follows the Netherlands and NICE sources. Netherlands guidance recommends secondary obstetric care after 24 hours (category C). NICE recommends transfer to obstetric care after “rupture of membranes more than 24 hours before the onset of established	33

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			labour.”	
F	21	Genital herpes. While this is an important risk factor and is already included in the OARs, it is not appropriate for all genital herpes to fall under the high risk list. Both the British Columbia and the Ontario College of Midwives guidelines call for transfer when there is an active herpes outbreak in labor or at rupture of membranes. Many HSV positive women are excellent candidates for homebirth as long as they do not have an outbreak at the time of labor.	Guidance language changed to “active infection (outbreak) of genital herpes” in accordance with NICE and to address one commenter’s concern.	34
F	22	Thick meconium staining of amniotic fluid. While this is a recognized risk factor, this item is more appropriate for rule and practice standard and does not make sense in coverage guidance. Home birth providers will be in situations where they are dealing with thick meconium staining and each case will need to be considered individually by the provider taking into account distance from hospital, if delivery is imminent, and other factors.	Our inclusion of thick meconium as a factor requiring transfer is based rating as a Netherlands C (secondary obstetric care) indication. From the Netherlands guidance: “When one of the items mentioned below occurs, an attempt should still be made to achieve an optimal condition for further intrapartum care, whilst referral to secondary care may be urgent, depending on the situation. When referring from the home situation, the risk of transporting the woman also needs to be included in the considerations.” Revise language to include “Thick meconium staining of amniotic fluid” as a criterion for transfer. Language about imminent deliveries was added, but not specifically to this criterion.	35
F	23	Retained placenta. This is a strange item to include in coverage guidance because retained placentas do happen and the provider at hand will need to determine what is the safest course of action depending on the clinical picture. There will be cases where the safest course of action will be administration of anti-hemorrhagics and/or attempted manual removal before or during initiation of transport to hospital. This	Retained placenta is an indication for transfer to a hospital, whether or not management by an out-of-hospital provider is initiated before or during transfer. Original box language recommended transfer for retained placenta without a defined time cutoff. A 60 minute cutoff has been added to coverage	36 37

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ID	#	Comment	Disposition	High-Risk Table Line
		is an item that should be, and is, in rule and practice standards but does not make sense for coverage guidance.	guidance to be consistent with birth center criteria. NICE recommends urgent transfer if uterine exploration is necessary. Ontario – consultation indication Netherlands – C (secondary care)	
F	24	Third or fourth degree, or periurethral, laceration. This item is confusing for a coverage recommendation especially alongside “laceration requiring hospital repair” as third and fourth degree repairs are outside of our scope of practice, but sometimes a physician or nurse-midwife will come do these repairs in the home setting so as not to interrupt the postpartum period. For these reasons this item seems inappropriate for coverage guidance.	“Laceration requiring hospital repair (e.g., extensive vaginal, cervical or third- or fourth-degree trauma)” is listed in the box language as an intrapartum criterion for transfer to hospital. Third-degree laceration not requiring hospital repair is a criterion for consultation. Third-degree and fourth-degree laceration occurring in a previous pregnancy are listed as high-risk criteria necessitating consultation prior to planned out-of-hospital birth. This is consistent with NICE guidance as found in Table 9: “Extensive vaginal, cervical, or third- or fourth-degree perineal trauma.” History of a fourth-degree laceration without satisfactory functional recovery is a criterion for planned hospital birth.	9 8
F	25	Please seriously reconsider the length and scope of the high-risk list. Healthy pregnant women who are covered by the Oregon Health Plan have a right to informed choice of provider type and place of birth. The HERC should be cautious in recommending against coverage for basic maternity and newborn care in healthy women and restrict its recommendations to those conditions that are truly high risk for an out of hospital setting.	Coverage guidance has been edited to reflect a distinction between high-risk coverage exclusion criteria, and criteria for consultation or transfer when planning out-of-hospital birth.	NA
G	1	As chairman of the Midwife Committee for the All Care Health Plan in Grants Pass, Oregon, I am writing to convey our concerns regarding the coverage guidance for planned home birth.	Thank you for your comments.	NA

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G	2	In addition to the concerns detailed below, we ask that a temporary rule change be made to not allow home births until the guidelines can be finalized. In their current state, we feel the guidance violates all aspects of the triple aim. If a bad maternal or fetal outcome occurs during a home birth that could have been prevented by improved guidelines, that decreases the quality of the patient's experience, directly lowers the quality of care, and will substantially increase the cost of care. Therefore, we ask that you seriously consider the additions/changes to the guidelines below.	Home birth is currently covered by fee-for-service Oregon Health Plan. HERC will review the Coverage Guidance and consider it in making potential changes to the Prioritized List of Health Services for the Oregon Health Plan. Once any changes to the Prioritized List are complete, rule changes would need to be made.	NA
G	3	Before getting to those specific details, there are other vital points we ask that you also consider. <ul style="list-style-type: none"> • Need for midwives to have appropriate malpractice insurance. • Need for increased litigation protection for OB and Pediatric physicians who take care of failed planned home births and/or their subsequent complications. • Patients who refuse to adhere the guidelines needs to sign an informed refusal consent form. 	All women giving birth out of hospital should have a full informed consent procedure. System characteristics associated with safe out of hospital birth include a system of consultation and referral/transfer that can assure seamless care. Written agreements that cover consultation/referral/transfer and a well-defined and practiced system of transfer are important as noted in the coverage guidance document.	38
G	4	Below are our overall recommendations: <ul style="list-style-type: none"> • Gestational age should be between 37 weeks/0 days and 40 weeks/6 days, thereby preventing a preterm or postdates birth. 	See comment A1.	1, 2
G	5	<ul style="list-style-type: none"> • Maternal age should be between 18 and 37 years old 	See comment D2.	7
G	6	<ul style="list-style-type: none"> • Place of planned home birth should be less than 15 min from the hospital providing obstetrical and pediatric care. Our past experience has proven that transfer plans are poor at best, and significantly contribute to the maternal/fetal morbidity and mortality. 	See comment E3.	NA
G	7	<ul style="list-style-type: none"> • Written transfer plan needs to be in effect that the accepting OB and pediatrician agree with. 	A “well-defined system of transfer” is in the document but no longer in the box language as a characteristic of a successful home birth.	38

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ID	#	Comment	Disposition	High-Risk Table Line
G	8	<ul style="list-style-type: none"> Increase the current time from 30 to 60 days where an infant stays on open card before being assigned to an appropriate health plan 	Enrollment issues are outside the scope of this coverage guidance.	NA
G	9	<ul style="list-style-type: none"> A first trimester screening should be done with an OB to establish the due date and review maternal history to decide if home birth is a viable option. 	Other types of maternity care providers, including midwives as well as family physicians, are qualified to assess dating, maternal history, and infectious disease screening.	NA
G	10	<ul style="list-style-type: none"> A 2nd trimester anatomy ultrasound done with an OB to rule out any gross physical abnormalities. 	See comment E1.	4
G	11	<ul style="list-style-type: none"> Subsequent reevaluation by OB if any complication arises later in pregnancy. 	Complications of pregnancy necessitating consultation or transfer are listed in the box language.	NA
G	12	<ul style="list-style-type: none"> The following labs needs to obtained, as they constitute standard of care: CBC, type and screen, hepatitis B, HIV, syphilis, gonorrhea, chlamydia, urine toxicology screen, gestational diabetes screen and repeat CBC at 28 weeks gestational age, and group B Strep screen at 35+ weeks gestational age. 	<p>See comment E2 (f).</p> <p>Urine toxicology screening may be appropriate in some patients at higher risk but is not universally recommended.</p> <p>Some of these labs may not be obtained due to a variety of factors including patient preference. Inadequate prenatal care may be a proxy for measurement, and women may refuse one or more of these tests.</p> <p>NICE says: At the booking appointment, for women who choose to have screening, the following tests should be arranged:</p> <ul style="list-style-type: none"> blood tests (for checking blood group and rhesus D status and screening for haemoglobinopathies, anaemia, red-cell alloantibodies, hepatitis B virus, HIV, rubella susceptibility and syphilis), ideally before 10 weeks urine tests (to check for proteinuria and screen for asymptomatic bacteriuria) ultrasound scan to determine gestational age using: <ul style="list-style-type: none"> ○ crown–rump measurement between 	15

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ID	#	Comment	Disposition	High-Risk Table Line
			<p>10 weeks 0 days and 13 weeks 6 days</p> <ul style="list-style-type: none"> ○ head circumference if crown–rump length is above 84 millimetres • Down's syndrome screening using: <ul style="list-style-type: none"> ○ 'combined test' at 11 weeks 0 days to 13 weeks 6 days • serum screening test (triple or quadruple) at 15 weeks 0 days to 20 weeks 0 days <p>Then discusses 28 weeks, Etc.</p> <p>EbGS decided that unknown HIV or HBV status should warrant a planned hospital birth, as early interventions could make a difference to the newborn.</p>	
G	13	<p>Below are our other recommendation that would negate a home birth or require transfer to a hospital:</p> <ul style="list-style-type: none"> • Complications in previous pregnancy/maternal medical history <ul style="list-style-type: none"> ○ History of 3rd or 4th degree laceration ○ History of prior fetal clavicle fracture ○ History of a blood clot, or bleeding disorder ○ History of a group B streptococcus infant ○ History of gestational diabetes ○ History of diabetes mellitus (Type 1 or Type 2) ○ History of prior birth weight 2'.. 9 lbs ○ Any history of genital herpes 	<p>Lacerations—see comments F9, F24.</p> <p>Fetal clavicle fracture—see comment E2</p> <p>Bleeding or coagulation disorder is Netherlands Category C (secondary obstetric care) and bleeding disorder in the mother is a NICE criterion for planned hospital birth.</p> <p>NICE table 6 lists “Risk factors associated with group B streptococcus whereby antibiotics in labour would be recommended” as indicating birth in an obstetrical unit. However, qualified providers in Oregon may administer group B strep prophylaxis outside the hospital setting and so this is not by itself a high-risk coverage exclusion criterion for out-of-hospital birth.</p> <p>Diabetes mellitus and gestational diabetes mellitus—see comment A2.</p> <p>Genital herpes-see comment F21.</p>	<p>8, 9</p> <p>10</p> <p>39</p> <p>41</p> <p>5</p> <p>34</p>

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ID	#	Comment	Disposition	High-Risk Table Line
G	14	<p>Complications in current pregnancy</p> <ul style="list-style-type: none"> ○ Any patient who would refuse a blood transfusion, as any postpartum hemorrhage can turn into a life-threatening event ○ Prolonged rupture of membranes greater than 18 hours, thereby increasing chance of neonatal sepsis and necessitating other treatment ○ Maternal seizure disorder ○ Severe maternal psychiatric disease ○ Any undiagnosed vaginal bleeding ○ Maternal hemoglobin < 11 ○ Maternal platelet count < 150,000 ○ Suspected macrosomia ○ Substance abuse, including marijuana 	See comment E2 regarding refusal of transfusion	11
			Prelabor rupture of membranes > 24 hours is a high-risk coverage exclusion criterion for planned out-of-hospital birth; none of the trusted sources provide evidence for an 18-hour cutoff. See also F20.	33
			Maternal seizure disorder: Netherlands B if medicated; should indicate consultation prior to planned home birth.	12
			Severe maternal psychiatric disease—see E2h.	16
			NICE specifies hemoglobin 8.5-10.5 as indication for individual assessment. Our recommendation specifies 10.5 as a consultation criterion and 8.5 as a high-risk coverage exclusion criterion.	40
			Abnormal bleeding is listed as an high-risk coverage exclusion criterion and a transfer criterion, based on Oregon Birth Center Criteria	39
			Thrombocytopenia is listed as a high-risk exclusion criterion, based on Oregon Birth Center and NICE criteria. Ontario lists it as an indication for consultation. See also comment J4.	43
			Fetal macrosomia is added as a criterion for consultation prior to planned home birth	14
			Drug or alcohol use with high risk for adverse effects to fetal or maternal health and mental health disorder requiring inpatient care are listed in box language as high-risk coverage exclusion criteria. Maternal mental illness under outpatient psychiatric care is a criterion for consultation.	16
				46
G	15	<ul style="list-style-type: none"> • Transfer to hospital <ul style="list-style-type: none"> ○ Any meconium, not just thick meconium 	Thick meconium is currently mentioned in the Oregon Birth Center absolute risk criteria.	35

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			<p>Meconium (any) is Netherlands C (secondary obstetric care)</p> <p>British Columbia lists “thick or particulate meconium” as indication for consultation</p> <p>See revised box language and comment F22.</p>	
G	16	<p>We fully realize the volatile and emotional aspects of home birth. We admit that we have dealt with past disastrous maternal/fetal outcomes, and as such we feel very strongly about this issue.</p> <p>Again, in their current state, we feel the guidelines violate all three aspects of the triple aim. We ask for your consideration for the above details. If we can provide any more information, please feel free to contact us.</p>	Thank you for your comments.	NA
H	1	<p>The Oregon Pediatric Society provides the following public comment regarding Oregon’s Home Birth Policy. When home births occur we support the American Academy of Pediatrics Policy Statement on Planned Home Birth:</p> <p>“The safest setting for a child’s birth is a hospital or birthing center, but the AAP recognizes that women and their families may desire a home birth for a variety of reasons. Pediatricians should advise parents who are planning a home birth that AAP and ACOG recommend only midwives who are certified by the American Midwifery Certification Board. There should be at least one person present at the delivery whose primary responsibility is the care of the newborn infant and who has the appropriate training, skills and equipment to perform a full resuscitation of the infant. All medical equipment, and the telephone, should be tested before the delivery, and the weather should be monitored. A previous arrangement needs to be made with a medical facility to ensure a safe and timely transport in the event of an emergency. AAP guidelines include warming, a detailed physical exam, monitoring of temperature, heart and respiratory rates, eye prophylaxis,</p>	Thank you for your comments and for including the American Academy of Pediatrics policy statement.	NA

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		<p>vitamin K administration, hepatitis B immunization, feeding assessment, hyperbilirubinemia screening and other newborn screening tests. If warranted, infants may also require monitoring for group B streptococcal disease and glucose screening. Comprehensive documentation and follow-up with the child’s primary health care provider is essential.”</p> <p>Although not detailed above, “other newborn screening tests” would include newborn blood spot screening as described by the Northwest Regional Newborn Screening Program, pulse oximetry screening for critical congenital heart disease and newborn hearing screening.</p>		
H	2	In practice, the manner by which infants are assessed for their candidacy for planned home birth is sometimes of concern. We agree that only those infants who are deemed “low risk” be candidates for home birth, but that their candidacy be determined based on widely accepted and complete prenatal care. This includes, but is not limited to a high quality prenatal ultrasound and completed testing for all routine maternal screenings, including HIV.	See comment E1.	15
H	3	Lastly, we believe the gestational age definitions included in the online report are too permissive. The March of Dimes has initiated successfully the “Healthy Babies are Worth the Wait” campaign to protect against elective birth prior to 39 weeks. This is because a broad literature describes the risks to infants born between 37 and 39 weeks which include respiratory difficulties, hypoglycemia, hypothermia, jaundice, feeding difficulties, learning challenges, and even death. We do not support planned home birth for infants < 37 weeks.	<p>See comment A1.</p> <p>The literature referenced here applies primarily to non-spontaneous labor occurring prior to 37 weeks’ gestation. Coverage recommendation on gestational age has been modified to 37 weeks 0 days through 41 weeks 6 days.</p>	1, 2
I	1	<p>This is to register my great concern on the HERC’s guidelines on planned homebirth in Oregon.</p> <p>I have read the proposed guidelines and do not think these are in the best interest of childbearing women in Oregon.</p> <p>Although it is vital to understand and to educate that certain very high-risk</p>	Thank you for your comments.	NA

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		<p>pregnancies will be better served in the hospital, using these (proposed) guidelines, in many cases, would rule out basic choice in basic maternity and newborn care for <i>HEALTHY WOMEN WHO ARE EXPERIENCING NORMAL PREGNANCIES</i>.</p> <p>Licensed midwives in Oregon work under risk assessment guidelines which are evidence-based and we continually assess and reassess women to evaluate who may need a consult with an MD or OB or other specialist and who may be too high risk for out of hospital birth.</p>		
I	2	<p>I have read [commenter F]'s letter to HERC on behalf of the Oregon Midwifery Council, and must say that I agree with [their] very specific comments, point by point, and I would refer you to that letter rather than renaming those points here. [Their] statements are a reflection of [their] extensive experience as a midwife and as an ardent researcher in the maternity care literature.</p> <p>As per [commenter F]'s letter, I agree that apparently, the HERC has identified certain risks for home birth that are truly research-based but has included as well many potential risk factors that are NOT based in research or that have no reason to be included in guidance for coverage.</p> <p>These items need to be addressed and hopefully removed from the list so that the HERC guidelines can be considered to have integrity and to be actually true to the task of providing "Evidence Based Recommendations."</p> <p>From my own limited experience as a midwife (>400 births) I can say that I have helped women with each of ([commenter F]'s named) risk factors and have had good outcomes. Risk assessment is an ongoing task for the midwife throughout the prenatal and birth and postnatal period, so that each woman and baby are assured the best outcomes.</p>	See comments C1, C2, and F2.	NA
J	1	<p>The ingredients necessary for good outcomes in out of hospital (OOH) births are not a secret. The literature shows that you need well-trained midwives, good transfer policies, and appropriate candidate selection.</p> <p>I agree with your concept of adopting coverage guidelines for Oregon that</p>	Thank you for your comments.	38

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		incorporate the risk criteria used in Canada, UK, and the Netherlands.		
J	2	<p>I have a few suggestions for changes in the wording that I think would improve the draft.</p> <p>“Planned Home Birth” should be changed back to “Planned Out-of-hospital birth.”</p> <p>The coverage guidelines should pertain to all OOH births, both home and birth center. In Oregon, many birth attendants work both in birth centers and also do home births. Birth centers do not provide any additional safety features over home birth for high risk situations. The current birth center rules exclude twins and breech, but allow Previous C-section, postterm pregnancies up to 43 weeks, and hypertension up to 150/100.</p> <p>I think it is already confusing to the consumer that there are two sets of rules – one for LDMs through the BDEM, and another for Birth Centers. I think it would compound the confusion to have two sets of coverage guidelines.</p>	<p>The Licensed Direct Entry Midwife Staff Advisory Workgroup specifically requested the HERC to develop a coverage guidance related to planned home birth. The primary source (NICE) groups home birth and freestanding or alongside midwifery-led units as appropriate choices for low-risk women.</p> <p>In light of this, we have changed the title to “Planned out-of-hospital birth.” It is appropriate to have a single set of criteria pertaining to all types of out of hospital births.</p>	NA
J	3	<p>In my view, “High risk conditions necessitating consultation or transfer include.....” should be changed to “High risk conditions necessitating transfer to a hospital provider include.....”</p> <p>In Canada, the UK, and the Netherlands, the licensed midwives have admitting privileges to hospitals. The criteria for consultation and transfer apply to women who labor both in and out of hospitals. There are some patients who have high risk conditions that make them inappropriate candidates for OOH births, but whose labors can still be attended by midwives in the hospital in consultation with a physician.</p> <p>In Oregon, the vast majority of midwives who attend OOH births do not have hospital privileges, so high risk clients should be transferred to a provider with hospital privileges.</p> <p>Currently, Oregon rules for LDMs regarding consultations for high risk</p>	<p>Coverage guidance has been edited to reflect a distinction between exclusion criteria for coverage of planned out-of-hospital birth, and those that necessitate antepartum consultation with a provider who has expertise in caring for higher risk pregnancies and when planning out of hospital birth and the ability to admit to a hospital. See also comment F2 and revised coverage recommendations.</p>	NA

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		clients, OAR 332-025-0021 (7) and (8), do not require that the consultation be with a physician with hospital privileges. The consultation can be with a physician, a PA, a CNM, a Naturopath, or another LDM with “direct experience”. I believe the word “consultation” in your draft should be removed.		
J	4	<p>I would recommend more precise definitions of certain risk criteria to avoid confusion. There are some discrepancies between the LDM rules, the birth center rules, and standard definitions in the medical literature. My suggestions are:</p> <ul style="list-style-type: none"> a. “Fetal growth retardation” should be changed to “Intrauterine growth restriction”. b. “Eclampsia, pre-eclampsia or pregnancy-induced hypertension, hypertension (before or after delivery) with blood pressure >140/90.” Both ACOG and SOGC use a systolic of 140 or a diastolic of 90 to define gestational hypertension. (1,2) NICE (p. 30) recommends transfer to obstetric care for “either raised diastolic blood pressure (over 90 mmHg) or raised systolic blood pressure (over 140 mm Hg) on 2 consecutive readings taken 30 minutes apart.” c. “Chorioamnionitis or other serious infection with fever >38 C.” Three out of the eight OOH fetal/ neonatal deaths in Oregon in 2012 had chorioamnionitis. d. “Thrombopenia” should be changed to “Thrombocytopenia with platelets <100,000.” e. “Uteroplacental Insufficiency and Intrauterine Growth Restriction.” f. “Retained placenta >1 hour.” 	<ul style="list-style-type: none"> a. “Fetal growth retardation” language was taken from the Netherlands guidance and has been changed to “Intrauterine growth restriction” for consistency. b. Box language has been edited to reflect NICE cutoffs for hypertension as a criterion for transfer. c. Box language presently includes “chorioamnionitis or other serious infection” and temperature ≥ 38.0 C as separate transfer criteria. Maternal temperature is only one piece of the diagnostic criteria for chorioamnionitis. d. The word “thrombopenia” has been changed to “thrombocytopenia” for consistency. NICE table 6 does include cutoff of 100,000. e. “Uteroplacental insufficiency” and “Intrauterine growth restriction” are presently listed separately in the box language. f. Box language recommends transfer for retained placenta without a defined time cutoff. Oregon birth center criteria list a 3-hour cutoff. Netherlands, Ontario, and British Columbia guidances do not define a time cutoff for retained placenta. A sixty-minute cutoff has been added to coverage guidance to be consistent with NICE. 	<p>31</p> <p>42</p> <p>44</p> <p>43</p> <p>32</p> <p>37</p>
J	5	<p>I think “failure to progress” also needs to be defined. Two out of the eight OOH fetal/neonatal deaths in Oregon in 2012 had prolonged labor. Some options:</p> <ul style="list-style-type: none"> a. The Dutch criteria for failure to progress in the first stage of active 	The definitions in a. through d. are correct. The box language does not presently include a definition of delay of labor. Defining “delay of labor” is a practice guideline definition outside the scope of	20

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		<p>labor is “no change in the cervix or progress in dilation after the latent phase for a duration of 4 hours”. Failure to progress in the second stage of labor is “lack of progress after a maximum of one hour, in cases with full dilation, ruptured membranes, strong contractions and sufficient maternal effort.”</p> <p>b. NICE (p. 57) states that delay in the first stage of active labor is suspected if cervical dilatation is less than 2 cm in 4 hours. Diagnosis of delay in the active second stage (p. 60) is after 2 hours for nulliparous woman and one hour for multiparous woman.</p> <p>c. ACOG recently defined arrest of labor in the first stage of labor as no cervical change in 4 hours of adequate contractions or 6 hours of inadequate contractions. In the second stage, 2 hours of pushing in multiparous women and 3 hours in nulliparous women.(3)</p> <p>d. LDM rule OAR 332-025-0021 (5)(b)(F)(i) defines lack of adequate progress in second stage for vertex presentation “is when there is no progress after a maximum of three hours in cases with full dilation, ruptured membranes, strong contractions and sufficient maternal effort. (Note: In this rule, this situation is considered non-absolute and requires a consultation, but not necessarily transfer.)</p> <p>e. My preference is a hybrid: First stage – no change in the cervix or progress in dilation after the latent phase for a duration of 4 hours. Second stage – 2 hours of pushing in multiparous women and 3 hours in nulliparous women. (Non-emergency transport can take up to an additional hour.)</p>	coverage guidance.	
J	6	For Postpartum complications, “Transfer to a higher level of care is recommended in the following circumstances:” should be changed to “The following post-partum complications require transfer to a hospital:”	Thank you for the suggestion. See revised box language.	NA
J	7	I agree that Previous Cesarean Section is a situation that should remain on the high risk list. In the recent MANAstats dataset of home births in the US, the intrapartum + neonatal death rate for term VBACs was 4.75/1000 compared to 1.24/1000 for	Thank you for your comment.	NA

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		<p>women with no previous C-section in the same study. (4) OOH births use intermittent auscultation for fetal surveillance which is appropriate for low risk labors if done properly, but is not appropriate for VBACs. Quoting from the SOGC guidelines for intrapartum fetal surveillance: “For women attempting VBAC, there is little controversy. All professional jurisdictions recommend continuous electronic fetal monitoring.” That includes ACOG, SOGC, and RCOG. (5)</p>		
K	1	<p>My name is [commenter K] and I am a licensed Registered Nurse in the state of Oregon. I have had the choice and privilege to birth my three children safely and gently at home over the past several years.</p> <p>I am pleased that you have put forth a great effort to lay out guidelines for women in Oregon who want more comprehensive choices in their prenatal care and birth experiences. I am also thankful that these choices will be more readily available to women on OHP and related health insurances.</p> <p>I am concerned, however, with some of the restrictions placed in the proposed guidelines, and fear that some of them may inappropriately hinder otherwise healthy candidates for home births with safe outcomes. Some of the proposed restrictions on what is defined as "high risk" pregnancy fail to take into consideration individual situations and the possibility of individualized care rather than providing "blanket labels" on what is or isn't "safe enough."</p>	Thank you for your comments.	NA
K	2	<p>My firstborn was born at 41 weeks and 2 days; 2 days beyond your recommended 36-41 week window, and I had a safe birth and healthy and safe outcomes for my child and myself. I understand that it is not uncommon for first births to be as much as 10 days late, give or take, with no adverse outcomes. I took care to monitor utero activity on a daily basis, as recommended both by my midwives, and also by literature I had received from an OB clinic before my transfer of care to a midwife team.</p>	<p>Thank you for sharing your experience.</p> <p>Cutoff of 41 weeks is endorsed by ACOG. NICE does include pregnancy up to 41 completed weeks, or 41 weeks+ 6 days. The coverage guidance language uses 41 completed weeks of gestation which comports with the NICE definition.</p>	2
K	3	<p>According to a simple calculator, I have a BMI over 35, but you would never guess that just looking at me. Just a few years ago, I was 5ft 6in and 180lb. (BMI about 30), but I was fit enough to run a 10K in one hour, thin enough to count all my ribs in the</p>	<p>NICE table 7 lists “Body mass index at booking of greater than 35 kg/m²” as indicating increased risk, suggesting planned hospital</p>	30

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		<p>mirror, and lean enough to not be able to float in a pool to save my life. (I'd sink like a rock without actively swimming...it was impossible for me to do a dead-mans-float.) I had a flat stomach, and I ran a couple miles every day...but the BMI chart said I was overweight. Now, a little heavier and a little less active, I'm actually at just over a BMI of 35, but I'm still active, still healthy, have low cholesterol, and no indicators of diabetes, pre-diabetes, or high blood pressure. The typical BMI scale and chart doesn't accurately reflect my health status, but through an objective lens, a well-trained care provider would tell you that I'm a little overweight, but otherwise healthy.</p> <p>I know I'm not the only person like this. There are other women out there who are predisposed to higher muscle mass, whether genetically and/or through training. A BMI chart should be a tool in the overall evaluation of a candidate, not a defining point in whether or not services can or cannot be provided.</p>	<p>birth.</p> <p>EbGS decided to make it a criterion for consultation as risks are higher for some women and not for others, such as those that have had a number of uncomplicated prior births.</p>	
K	4	<p>I also have O- (RH negative) blood, and my husband has the Rh factor (Rh+), and all my children were consequently born with Rh+ blood, but I have had safe and healthy outcomes in all my pregnancies and births. My trained midwives were attentive to my needs and I had regular lab draws to monitor for any adverse reactions. A trained midwife is still a trained healthcare provider, and should be treated as such. Everything I was told that I would have available to me in the OB setting, I still had available to me in the midwife/home-birth setting of my care (Rhogam shots, appropriate and recommended lab draws, regular urine screening, blood glucose screening, newborn hearing screening, newborn lab draws, etc.)</p>	<p>Active blood group incompatibility is Netherlands category C (secondary obstetric care). NICE also lists “atypical antibodies which carry a risk of haemolytic disease of the newborn” as indicating birth in an obstetrical unit. The coverage guidance has been revised to include “Blood group incompatibility with atypical antibodies, or Rh sensitization” as a high risk coverage exclusion criterion for hospital birth to align with NICE.</p>	45
K	5	<p>As a trained healthcare provider myself, I see great potential in allowing women a better spectrum of choices in their prenatal and birthing experience. From firsthand experience, my care has been infinitely better and more comprehensive with a team of midwives versus a trained OB. For one, a typical OB visit is 15 minutes and they don't have the time or availability to provide holistic care to their clients. Their agenda is compressed into a "one-size-fits-all/most" model of the pregnancy process and they miss much opportunity to address specific points or concerns related to the individual woman. Consequently, if problems arise (even minor ones),</p>	<p>Thank you for your comments.</p>	NA

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		the OB is forced to be reactive to the situation rather than proactive before the issue arises.		
K	6	With a midwife as the trained provider, the average prenatal visit is one hour, and each visit is tailored to the individual woman and her pregnancy experience. In-depth discussions are focused on things like diet, rest and exercise, new or ongoing stressors in the mother-to-be's life, etc. and all of which may have a direct impact on the pregnancy and/or birthing experience. More time is also afforded to discuss various treatment plans and options that relate to the individual woman and her preferences. Skilled midwives, therefore, have more of an ability to be proactive in a woman's care and to address potential risks before they start or get out of hand. In this sense, having a trained midwife can be viewed as choosing a more prophylactic route to a positive pregnancy and birth outcome.	Thank you for your comments.	NA
K	7	<p>A skilled midwife, like a skilled OB, will have the client's best interest in mind, and will transfer care to a more skilled group if the situation necessitates. Just like an OB may transfer care of a high-risk patient to a more skillfully trained OB or specialist, or refer a woman to a more acute facility (Hospital instead of a birthing facility, or higher level hospital instead of community hospital), a midwife also has the ability and duty to refer a client to a more skilled professional or facility if the situation exceeds her scope of care.</p> <p>Autonomy should not be stripped from a trained and skilled provider. I think the stringency of the guidelines in the proposal should be modified so that trained and licensed midwives can still practice within the scope of what they were trained. Even VBAC's and Breach births can have healthy and safe outcomes at home if attended by a skilled midwife. And sometimes less intervention is more as far as quality of care and outcome.</p>	See comment C1.	NA
L	1	<p>I am not sure if or how this information will be of use to you, but HERC should know these things.</p> <p>The HERC draft greatly understates the mortality difference between planned</p>	It is true, as the commenter states, that the data we cite may group pre-labor fetal death with intrapartum death and that some hospital deliveries where there was pre-labor fetal death may have been originally planned as out-of-hospital births. However, it is	NA

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		<p>hospital births and planned out-of-hospital (OOH) births in Oregon in 2012.</p> <p>The report on 2012 Oregon births by planned birth place (1) and HERC draft both say that “The term perinatal mortality rate for planned OOH birth (4.0/1,000 pregnancies) was nearly twice that of in-hospital births (2.1/1,000)” (1). That is true, but the comparison is misleading because the perinatal mortality rate for planned hospital births included an unknown but relatively large number of antepartum (AP) fetal deaths that occurred <i>before</i> the mother was in labor. Eighty-five to 90 percent of all fetal deaths in developed countries are <i>stillbirths prior to labor</i> (2), and the incidence increases with gestational age (3) and thus is highest among term births.</p> <p>Most women whose babies die before labor go to a hospital to have labor induced and deliver their dead fetus in the hospital. In contrast to antepartum fetal deaths, intrapartum (IP) fetal deaths <i>during labor</i> are very rare in hospitals in developed countries, <i>only about 1 per 10,000</i> births (4). There were no intrapartum fetal deaths in a prospective 1980s study of almost 35,000 hospital births using either selective (for high-risk pregnancies) or universal electronic fetal monitoring (5). Antepartum fetal deaths comprise the vast majority of all fetal deaths that occur in American hospitals.</p> <p>Fifty-eight term fetal deaths were <i>associated with</i> 39,990 planned hospital births in Oregon in 2012 (1). We don’t know how many were IP, but it is highly unlikely that more than six fetal deaths occurred during labor in Oregon hospitals that year. Four intrapartum fetal deaths were associated with planned OOH births in Oregon in 2012. All four were investigated by a public health pediatrician; all of them were intrapartum.</p> <p>It is misleading to compare a perinatal mortality rate that included an unknown but relatively high proportion of the 58 term fetal deaths associated with nearly 40,000 planned hospital births in Oregon in 2012 with the perinatal mortality rate for planned 2,021 planned OOH births, which included 4 early neonatal deaths and 4 intrapartum fetal deaths but no antenatal fetal deaths.</p>	<p>also true that chart review of the eight term fetal deaths and early neonatal deaths from the Oregon birth study shows that six of these deaths would not have met the criteria for coverage as outlined in this coverage guidance. The 2012 Oregon mortality rate, when adjusted for risk factors that should have excluded women from attempting OOH birth (and which this coverage guidance does not support) lies within the range of rates seen in the international and U.S. literature for both OOH and low-risk hospital births.</p>	

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L	2	<p>The draft Guidance does not address the educational qualifications of home-birth attendants in Oregon.</p> <p>The reviewed evidence is based primarily on studies from the Netherlands, Ontario and British Columbia. <i>All</i> midwives who attend home births in those jurisdictions are educated to the standards in the International Confederation of Midwives (ICM) Definition of the Midwife (6) and Global Standards for Basic Midwifery Education (7), as are all certified nurse-midwives (CNMs) in the United States (US). ICM defines a “midwife” in part as a person who has completed a three-year midwifery education program, or 18 months for students who enter as nurses or other healthcare professionals (6,7).</p> <p>In contrast to home births in those jurisdictions, most OOH births in Oregon are attended by direct entry midwives (DEMs), naturopaths and others with less midwifery education. In 2012, 62 percent of all planned out-of-hospital (OOH) births were attended by DEMs, 25 percent by CNMs, 11 percent by naturopaths (1).</p> <p>DEMs are limited to OOH births. Although some are knowledgeable and competent, some aren’t; very few have completed a midwifery curriculum that meets ICM standards. Most, including certified professional midwives (CPMs), are trained through apprenticeship and self-study (8,9).</p> <p>Most naturopaths who attend births in Oregon graduated from the National College of Naturopathic Medicine (NCNM) in Portland. One three-credit lecture course in natural childbirth is part of the curriculum for all naturopathic physicians (10). NCNM also offers four three-credit lecture courses, one each on pregnancy, labor and birth, the postpartum period, and neonatology. Films are used to enhance lectures on techniques for monitoring the fetal/maternal condition and progress of labor, complications of labor and birth are discussed and skills needed to respond to them are demonstrated. Although NCNM does not provide any supervised clinical experience with pregnant women (10), to be licensed in Oregon naturopaths must have observed and assisted in 50 births supervised by a naturopath or obstetrician, pass a test and complete 15 hours of continuing education every year (11).</p>	<p>Thank you for your comment and information. Oregon law allows practice by midwives and other providers who do not have ICM standards of education. The draft guidance states “Certification requirements for the practice of midwifery vary significantly between the US and other countries, with US requirements being less rigorous with regard to both years of formal education and experience. See also comment F6.</p> <p>Box language requires home birth providers to be certified and licensed.</p>	NA

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		<p>CNMs attended only 25 percent of all planned OOH births in Oregon in 2012. All CNMs are educated to ICM standards in masters’ degree programs, including one at OHSU.</p> <p>The IP fetal death rates from studies of home births attended by midwives who meet ICM education standards were zero in the small study from British Columbia, 0.31/1000 births in the very large study from the Netherlands, 0.45 in Ontario, and 0.36/1000 in England (12,13). In comparison the rate was 1.3 in a 2014 study of nearly 17,000 home births attended by members of the Midwives Alliance of North America (MANA) (14), four times higher than the mean rate if findings from all four of the ICM-education standard studies were combined. Eighty-five percent of births in the MANA study were attended by midwives who don’t meet ICM education standards (15). The Ontario study reported total neonatal mortality (NN) instead of early NN mortality. ENN is preferable and was reported by the other three studies. The IP+NN rate for the Ontario study was 1.35/1000 births and 2.07/1000 for the MANA study. The IP+ENN mortality rates for the studies from British Columbia, the Netherlands and England were 0.35, 0.64 and 0.65 respectively. At 1.71/1000, the IP+ENN mortality rate for the MANA study (14) was more than three times higher than the average for the studies based on births attended by midwives who meet ICM education standards.</p> <p>Intermittent auscultation is used to monitor the fetal heart rate in OOH births (15). It requires concentrated attention and a deep understanding of fetal heart rate changes and their significance during labor. Home birth midwives must be proficient in intermittent auscultation.</p>		
L	3	HERC should add distance or time (not more than 30 minutes) from the home-birth residence to a hospital staffed and equipped to provide emergency care to a parturient woman or newborn to the criteria for coverage.	See comment E3.	NA
M	1	The Health Evidence Based Rules Commission (HERC) is in the process of developing Home Birth Draft Coverage Guidance defining low risk pregnancy that would be appropriate for planned home birth, as well as for maternal or pregnancy conditions	See comments D2, E1, E2, and G14.	

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		<p>that would indicate the need for a higher level of prenatal, antenatal or postpartum care. Trillium Community health Plan would like to provide a list of additional guidelines to consider when drafting coverage guidance.</p> <ul style="list-style-type: none"> • Should complications occur at any point in the pregnancy, a re-evaluation should be performed to determine risk/status level. • Low risk characteristics should include an ultrasound between 12 – 30 weeks. • Low risk characteristics should include maternal and paternal age parameters such as 18 – 45 years of age. • Complications in a previous pregnancy should include third degree lacerations. • Complications of a previous pregnancy should include fractured clavicle and shoulder dystocia. (currently just shoulder dystocia) • Complications of a previous pregnancy should include history of large babies (>9 pounds). • Complications of current pregnancy should include having an IUD in place when becoming pregnant. • Complications of a current pregnancy should include parental Jehovah’s Witness status – due to inability to transfuse. • Complications of current pregnancy vaginal delivery after C section. • Complications of a current pregnancy should include incomplete prenatal testing such as strep and all STDs. • Complications of a current pregnancy should include severe mental health issues not well controlled or addressed. • Transfer to a higher level of care considerations should include a transfer plan or protocol for DEMWs to include a transfer or back up plan for Obstetricians should be included. 		<p>15</p> <p>4</p> <p>7</p> <p>8</p> <p>10</p> <p>13</p> <p>6</p> <p>11</p> <p>3</p> <p>15</p> <p>16</p> <p>38</p>

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C2	<p>Midwives' Association of Washington State INDICATIONS FOR DISCUSSION, CONSULTATION, AND TRANSFER OF CARE IN AN OUT-OF-HOSPITAL MIDWIFERY PRACTICE http://www.washingtonmidwives.org/documents/MAWS-indications-4.24.08.pdf</p>
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Appendix 1

Midwives' Association of Washington State

INDICATIONS FOR DISCUSSION, CONSULTATION, AND TRANSFER OF CARE IN AN OUT-OF-HOSPITAL MIDWIFERY PRACTICE

2. DEFINITIONS:

2.1 DISCUSSION WITH ANOTHER MIDWIFE, AN ARNP, OR A PHYSICIAN

A discussion refers to a situation in which the midwife seeks advice or information from a colleague about a clinical situation, presenting her management plan for feedback.

2.1.1 It is the midwife's responsibility to initiate a discussion with and provide accurate and complete clinical information to another midwife, a nurse practitioner, or a physician in order to plan care appropriately. This discussion can take place between midwives in the same practice.

2.1.2 Discussion should occur in a timely manner soon after the clinical situation is discovered.

2.1.3 Discussion may occur in person, by phone, fax, or e-mail.

2.1.4 Discussion may include review of relevant patient records.

2.1.5 Discussion may include request for prescriptive medication based on signs or symptoms and/or laboratory results.

2.1.6 Discussion should be documented by the midwife in her records. Documentation of discussion should refer only to practitioner type without specifying the name of the practitioner contacted. Documentation should also include the midwife's management plan.

2.1.7 Discussion need not occur if the midwife has previously encountered a particular situation, discussed it with a colleague, developed a management plan, and is currently managing the same clinical presentation. In this case, documentation of the management plan and discussion with the client of the management plan is sufficient.

2.2 CONSULTATION WITH A PHYSICIAN

A consultation refers to a situation in which the midwife, using her professional knowledge of the client and in accordance with this document, or by client request, seeks the opinion of a physician competent to give advice in the relevant field. The consultant will either conduct an in-person assessment of the client or will evaluate the client's records in order to address the problem that led to the consultation.

2.2.1 It is the midwife's responsibility to initiate a consultation and to communicate clearly to the consultant that she is seeking a consultation.

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2.2.2 A consultation can involve the physician providing advice and information, and/or providing care to the woman/newborn, and/or prescribing treatment for the woman or newborn.

2.2.3 In the case of an in-person consultation, the midwife should expect that the consultant will promptly communicate findings and recommendations to the client and the referring midwife after the consultation has taken place.

2.2.4 Where urgency, distance, or climatic conditions do not allow an in-person consultation with a physician when it would otherwise be appropriate, the midwife should seek advice from the physician by phone or other similar means. The midwife should document this request for advice in her records and discuss the consultant's advice with the client.

2.2.5 It is the midwife's responsibility to provide all relevant medical records to the consultant, including a written summary of the client's history and presenting problem, as appropriate.

2.2.6 Consultation must be fully documented by the midwife in her records, including the consultant's name, date of referral, and the consultant's findings, opinions, and recommendations. The midwife must then discuss the consultant's recommendations with the client.

2.2.7 After consultation with a physician, care of the client and responsibility for decision making, with the informed consent of the client, either continues with the midwife, is shared collaboratively by the midwife and the consultant, or transfers completely to the consultant. Transfer or sharing of care should occur only after dialogue and agreement among the client, the midwife, and the consultant.

2.3 TRANSFER TO A PHYSICIAN OR OTHER QUALIFIED HOSPITAL-BASED PROVIDER

When care is transferred permanently or temporarily from the midwife to a qualified hospital based provider, the receiving practitioner assumes full responsibility for subsequent decision making, together with the client. For guidance about intrapartum transfers, see also the MAWS document Planned Out-of-Hospital Birth Transport Guideline.

3.1 PRE-EXISTING CONDITIONS AND INITIAL HISTORY

Discussion:

- family history of significant genetic disorders, hereditary disease, or congenital anomalies
- history of pre-term birth (< 36 weeks)
- history of IUGR
- history of severe postpartum hemorrhage
- history of severe pre-eclampsia
- history of gestational diabetes

Consultation:

- history of uterine surgery, including: myomectomy, hysterotomy, or prior cesarean birth
- current or significant history of cardiovascular disease, renal disease, hepatic disorders, neurological disorders, severe gastrointestinal disease

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- current or significant history of endocrine disorders (excluding controlled mild hypothyroidism)
- pulmonary disease/active tuberculosis/asthma if severe
- collagen-vascular diseases
- significant hematological disorders
- current or significant history of cancer
- history of cervical cerclage
- history of 3 consecutive spontaneous abortions
- significant uterine anomalies
- essential hypertension
- history of eclampsia or HELLP
- previous unexplained neonatal mortality or stillbirth
- isoimmunization with an antibody known to cause hemolytic disease of the newborn
- history of postpartum hemorrhage requiring transfusion
- current severe psychiatric illness
- no prenatal care prior to third trimester
- current or history of epilepsy

Transfer:

- absent prenatal care at term
- any serious medical condition, for example: cardiac disease, renal disease with failure, insulin-dependent diabetes mellitus, or uncontrolled asthma

3.2 ANTEPARTUM CONDITIONS

Discussion:

- urinary tract infection unresponsive to treatment
- significant abnormal ultrasound finding
- well-controlled gestational diabetes
- persistent size/dates discrepancies

Consultation:

- significant abnormal Pap
- significant abnormal breast lump
- pyelonephritis
- ectopic pregnancy

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- molar pregnancy
- thrombosis
- fetal demise after 14 weeks gestation
- persistent anemia, unresponsive to treatment
- primary herpes infection
- significant vaginal bleeding
- premature pre-labor rupture of membranes (PPROM)
- isoimmunization, hemoglobinopathies
- persistent abnormal fetal heart rate or rhythm
- significant placental abnormalities
- documented intrauterine growth restriction
- unresolved polyhydramnios or oligohydramnios
- significant infection the treatment of which is beyond the midwife's scope of practice
- 42 completed weeks with reassuring fetal surveillance
- presentation other than cephalic at 37 weeks

Transfer:

- multiple gestation
- persistent transverse lie, oblique lie, or breech presentation
- persistent hypertension, HELLP, pre-eclampsia, or eclampsia
- placenta previa at term
- clinically significant placental abruption
- cardiac or renal disease with failure
- uncontrolled gestational diabetes
- known fetal anomaly or condition that requires physician management during or immediately after delivery

3.3 INTRAPARTUM CONDITIONS

In certain intrapartum situations, the midwife may need to act immediately and transport may not be the most prudent course of action in that moment. It is expected that the midwife will use her clinical judgment and expertise in such situations, access 9-1-1 if appropriate, and then transport if and when it becomes necessary.

Discussion:

- arrested active phase of labor (>6 hours of regular, strong contractions without any significant change in cervix and/or station and/or position)
- arrested 2nd stage of labor (>3 hours of active pushing without any significant change)

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- prolonged rupture of membranes (>48 hours)

Transfer:

- labor before 37 weeks
- transverse lie, oblique lie, or breech presentation
- multiple gestation
- sustained maternal fever (>100.4 F) or other evidence of maternal infection
- moderate or thick meconium
- persistent non-reassuring fetal heart rate pattern
- maternal exhaustion unresponsive to rest/hydration
- abnormal bleeding during labor
- suspected placental abruption
- suspected uterine rupture
- persistent hypertension
- pre-eclampsia
- maternal seizure
- ROM >72 hours or ROM >18 hours with unknown GBS status and no prophylactic antibiotics or GBS+ and no prophylactic antibiotics
- prolapsed cord or cord presentation
- significant allergic response
- active genital herpes in vaginal, perineal or vulvar area in labor or after ROM
- client's clear desire for pain relief or hospital transport

3.4 POSTPARTUM CONDITIONS

Discussion:

- urinary tract infection unresponsive to treatment
- mastitis unresponsive to treatment
- subinvolution

Consultation:

- breast abscess
- retained products/unresolved subinvolution
- sustained hypertension
- significant abnormal Pap
- postpartum depression

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Transfer:

- significant postpartum hemorrhage unresponsive to treatment, with or without sustained maternal vital sign instability or shock
- retained placenta (>1 hour or active bleeding and manual removal unsuccessful)
- lacerations beyond midwife's ability to repair
- unusual or unexplained significant pain or dyspnea
- significant hematoma
- endometritis
- postpartum psychosis
- maternal seizure
- anaphylaxis
- persistent uterine prolapse or inversion

3.5 NEWBORN CONDITIONS

It is strongly recommended that all newborns be seen by an appropriate pediatric provider by 2 weeks of age. The following conditions warrant contact sooner.

Discussion:

- low birth weight infant (< 2500 gm = 5 lbs 8 oz)
- loss of greater than 10% of birth weight

Consultation:

- persistent cardiac arrhythmias or murmurs
- significant clinical evidence of prematurity
- failure to thrive
- hypoglycemia
- significant jaundice in first 24 hours or pathologic jaundice at any time

Transfer:

- seizure
- persistent respiratory distress
- persistent central cyanosis or pallor
- persistent temperature instability
- persistent hypoglycemia
- Apgar score less than 7 at five minutes of age and not improving
- major apparent congenital anomalies
- birth injury requiring medical attention