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Birthing Center Rule Advisory Committee
October 18, 2021
2:00 p.m. via Zoom

RAC MEMBER ATTENDEES	
Colleen Forbes	LDM and former chair of the Board of Direct Entry Midwifery
Danielle Meyer	Oregon Association of Hospitals and Health Systems
Desiree LeFave	Bella Vie Gentle Birth
Hermine Hayes-Klein	Oregon Association of Birth Centers
Karen DeWitt	Oregon Association of Naturopathic Physicians
Kaylyn Anderson	Consumer
Meredith Mance	Aurora Birth Center
Silke Ackerson	Oregon Midwifery Council
Stefanie Rogers	Providence St. Vincent, Neonatologist
Michele Zimmerman-Pike	American College of Nurse Midwives
Willa Woodard	Rogue Birth Center
OTHER INTERESTED PARTY ATTENDEES	
Gabriela Esquivel	Community Health Worker, Samaritan Health Plans,
Holly Jo Hodges	Medical Director, Intercommunity Health Network CCO
Kati Dunigan	Community Health Worker, Samaritan Health Plans
Sean Connolly	Jackson Care Connect CCO
Sharron Fuchs	Public Citizen

OHA Staff	
Anna Davis	PHD-Health Facility Licensing & Certification
Barbara Atkins	PHD-Facility Planning & Safety
Lacey Martinez	PHD-Health Facility Licensing & Certification
Mellony Bernal	PHD-Health Care Regulation & Quality Improvement
Rebecca Long	PHD-Emergency Medical Services and Trauma Systems
Samie Patnode	Health Licensing Office, Board of Direct Entry Midwifery

Welcome and Overview
Mellony Bernal welcomed Birthing Center Rule Advisory Committee (RAC) members and reviewed housekeeping items. Participants were asked to enter their name, organization and whether they are a RAC member or member of public into the Chat.

Review of September 13th Meeting Notes

No comments.

Risk Factor Table I – Risk Factors for EXCLUSION AT ADMISSION

CURRENT PREGNANCY COMPLICATIONS
HIV (Unknown)
HIV (Positive)

- RAC member stated that it's extremely important that a person should be able to choose not to screen for HIV and this choice should not exclude someone from birth center care. It was further stated that a person should be able to choose to decline any screening for an infectious disease.
- RAC member expressed concern about a person declining HIV testing if not low risk. There are clear benefits to initiating early treatment for the newborn in decreasing transmission and it was noted that liquid antiretrovirals are challenging to obtain.
- RAC member indicated the need to respect a client's decision to not screen due to religion or culture which makes them low risk. Providers have a discussion with the client regarding the benefits of screening and the client should be able to decline and continue care at a birth center.
- RAC member via chat noted that they are generally opposed to removing the choice to birth at a birth center for the sole reason of declining testing.
- Staff asked what the protocol differences are for both the hospital setting and birth center setting for someone who has an unknown HIV status.
    - RAC member responded that in the hospital setting a rapid HIV screening can be conducted and if concerned about risk factors (such as injected substance use history), the hospital can initiate therapy with AZT, which is recommended within 6 hours of birth if there is concern for transmission. The earlier that therapy is started the lower the risk of transmission. It was noted that it is not common in the hospital setting to have someone decline testing as it is part of the OB panel. It was suggested that language be added relevant to risk status.
    - RAC member indicated that as long as the client is low risk, there shouldn't be any difference in treatment for people who refuse testing.
    - RAC member stated via chat that it is their understanding that rapid HIV is more likely to have a false positive result.

POLL: Retain HIV (unknown status) as an absolute risk factor? Results:

- 0% - I can say an enthusiastic yes to the recommendation (or action).
- 25% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 13% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.

- 25% - I do not fully agree with the recommendation and need to register concern. However, I will not block the recommendation. More discussion is necessary for full support.
- 38% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

Staff asked for those who voted to actively block, what other recommendation would you have?

- RAC member via chat indicated "unknown and low risk for HIV." Staff asked how low risk would be defined and whether it should be defined the same way for everyone.
  - RAC member responded that the list could be long.
  - Another RAC member noted via chat that delivery providers should be trusted to understand risk and shouldn't need to be defined.
  - RAC member stated concerns regarding restricting access to care for persons who are low risk. Uncertain what the added value is to test for low-risk scenarios. Trying to solve a problem that is not present in Oregon.
  - Several RAC members concurred with these comments.
- Another RAC member stated via chat "To be fully evidence based, I would like to see statistics on what the actual HIV positive status of prenatal testing here in OR is."
- RAC member stated via chat a suggestion that a written and signed informed declination form be included in the chart and then trust that a discussion of risk occurred and the client made an informed choice.
- RAC member suggested that HIV (unknown) should be removed altogether.

<u>POLL: Retain HIV (known positive status) as an absolute risk factor? Results:</u>

- 33% - I can say an enthusiastic yes to the recommendation (or action).
- 22% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 33% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 11% - I do not fully agree with the recommendation and need to register concern. However, I will not block the recommendation. More discussion is necessary for full support.
- 0% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

<u>Rubella (anytime during pregnancy)</u>

Staff noted that this risk factor is anytime during pregnancy. The prevalence is very low in the United States and would most likely come from foreign travel.

<u>POLL: Retain Rubella (anytime during pregnancy) as an absolute risk factor? Results:</u>

- 20% - I can say an enthusiastic yes to the recommendation (or action).
- 80% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 0% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 0% - I do not fully agree with the recommendation and need to register concern. However, I will not block the recommendation. More discussion is necessary for full support.

- 0% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

Syphilis (Unknown)
Syphilis (Positive)

- RAC member noted that most of the comments and issues discussed around HIV apply to syphilis. It was noted that a vast majority of clients are okay with the syphilis screening but there are some clients due to religious beliefs that refuse testing. This should not preclude a client from birth at a birth center. Known positives should be retained as an absolute risk factor.
- RAC member suggested including reference to low risk as suggested for HIV.
- RAC member commented via chat that positive status poses less risk after 24 weeks.
- RAC member remarked that they are assuming "positive" means "Positive untreated." If a person is still testing positive but is being treated the individual would be a candidate for an out-of-hospital birth. A person may have a positive RPR for years after treatment. It was suggested to change the wording to Positive – untreated.
- RAC member comments via chat that the Board of Direct Entry Midwifery (DEM) rules have this risk factor as a consult criteria for the reasons noted directly above and suggested voting on moving to consult. Staff asked for clarification on whether the suggestion is to move positive syphilis to consult and then a determination is made based on treated or untreated. RAC member agreed and stated that if anyone screens positive and it goes to consult with an appropriate provider then the determination can be made whether the client is appropriate for an out-of-hospital birth, if treated or not. It's more nuanced than no risk or high risk.
- Several RAC members concurred via chat to poll on moving to consultation.

POLL: Retain Syphilis (unknown status) as an absolute risk factor? Results:
- 0% - I can say an enthusiastic yes to the recommendation (or action).
- 23% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 11% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 33% - I do not fully agree with the recommendation and need to register concern. However, I will not block the recommendation. More discussion is necessary for full support.
- 33% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

POLL: Move Syphilis (positive status) to consultation? Results:
- 67% - I can say an enthusiastic yes to the recommendation (or action).
- 33% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 0% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.

- 0% - I do not fully agree with the recommendation and need to register concern. However, I will not block the recommendation. More discussion is necessary for full support.
- 0% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

POLL: Make Syphilis (positive status - untreated) an absolute risk factor? Results:

- 0% - I can say an enthusiastic yes to the recommendation (or action).
- 86% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 14% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 0% - I do not fully agree with the recommendation and need to register concern. However, I will not block the recommendation. More discussion is necessary for full support.
- 0% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

Varicella (current active infection at time of labor)

- RAC member asked for information about the risk to baby relating to this infection. RAC member responded that risk is different at different gestational ages. It was previously recommended to give VZIG which is not really available. IVIG is now recommended for the newborn if mom is active. This is very rare but there is a neonatal intervention and could be best managed with consultation with a specialist given risk of transmission to newborn.

POLL: Retain Varicella (active infection at time of labor) as an absolute risk factor? Results:

- 56% - I can say an enthusiastic yes to the recommendation (or action).
- 33% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 0% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 0% - I do not fully agree with the recommendation and need to register concern. However, I will not block the recommendation. More discussion is necessary for full support.
- 11% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

POLL: Move Varicella (active infection at time of labor) to consultation? Results:

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

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

- RAC member expressed concern and indicated that clarification should be provided that the risk factor is relating to primary infection and not shingles. Shingles (at time of labor) should not be a contraindication. Staff inquired whether the recommendation is to have that listed as a consult requirement. RAC member indicated that would reasonable but may not be necessary in every case.
- RAC members via chat concurred with comment above.

POLL: Add Shingles (at time of labor) as a consultation requirement. Results:
- 0% - I can say an enthusiastic yes to the recommendation (or action).
- 14% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 72% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 14% - I do not fully agree with the recommendation and need to register concern. However, I will not block the recommendation. More discussion is necessary for full support.
- 0% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

Mental Illness Requiring Inpatient Care
Staff noted that the risk factor is broadly written and doesn't have any indication of time frame. It was noted that the revised Health Evidence Review Commission (HERC) guidance has amended the risk factor reference. **Follow-up: HERC lists the following factors for consultation: 1) Maternal mental illness requiring psychological or psychiatric intervention; and 2) Patient currently taking psychotropic medications.**

- RAC member noted that based on the table, the risk factor is listed under current pregnancy complications and not under remote history. It was further stated that usually people who are in inpatient care are very complex, and unstable or may be on multiple medications to remain stable. A birth center would likely not have access to security or 24/7 access to a social worker or other mental health care provider. A client needing multiple resources for mental illness may be beyond the scope of a birth center.
- RAC member via chat stated, "Birth centers can safely care for clients with various mental health issues, including those who have received inpatient care during pregnancy. We request moving this to consult."
- Several RAC members concurred with statement above via chat.
- RAC member stated that mental health is so complex that place of birth should happen in consultation with the mental health care provider and team. There will be certain situations where birth at a hospital makes most sense, and other situations where a birth center would less problematic. With severe mental health issues, the midwifery team should be in contact with the mental health team, and those two teams along with the client make a plan together.
- RAC member stated via chat that "…the consult should be for a slightly broader category than the current language, 'requiring inpatient care.' Staff asked what the trigger should be. RAC member responded that requiring inpatient care is an extreme criteria. There are

situations where there may be a danger of harm to self or baby where the person doesn't require or is not able to get inpatient care and providers would hate not being able to have a consultation based on the deficiencies of the mental health care system.

- Staff asked to clarify that for purposes of a consult, it would be with the client's treatment team not just a random provider who does not know the client. RAC member concurred.
- RAC member stated they would concur with moving to consult.
- RAC member commented that yes, the client's mental health provider should be consulted with especially if the client is now stable. For someone in an unstable situation to lose midwifery care may be particularly difficult. It was further noted that birthing centers are in a position to provide home-based care and follow-up in a different way than a larger setting. While not mental health professionals, they can follow-up and contact the client's mental health provider and be a bridge. Women who first exhibit signs of postpartum depression have no idea they have depression and midwives would be beneficial.
- Staff asked RAC members what should occur for history of inpatient mental illness; should it be a consult or something else? RAC member responded that optimal care would be the midwife providing care and consulting with the mental health providers. If the illness is active during pregnancy, then consultation is mandatory. If the client is stable and has a good plan, then a consult should not be mandatory. Timing should not be addressed other than the current pregnancy. Staff asked, what about significant history in prior pregnancy. RAC member responded no, it would not change approach. Active symptoms right now are different than history. The client and provider should determine what is the best treatment plan.
- RAC members concurred with comment above via chat.

<u>POLL: Move mental illness (active during pregnancy) to consultation with mental health professional required? Results:</u>

- 25% - I can say an enthusiastic yes to the recommendation (or action).
- 36% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 13% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 13% - I do not fully agree with the recommendation and need to register concern. However, I will not block the recommendation. More discussion is necessary for full support.
- 13% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

Concerns were noted by RAC members about what was being voted on and whether it included mental illness requiring inpatient care. Poll was revised as follows:

<u>POLL: Move mental illness requiring inpatient care in the current pregnancy to consultation with mental health professional. Results:</u>

- 63% - I can say an enthusiastic yes to the recommendation (or action).
- 25% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.

- 13% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 0% - I do not fully agree with the recommendation and need to register concern. However, I will not block the recommendation. More discussion is necessary for full support.
- 0% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

Discussion concluded and next meeting will continue with placental conditions, prelabor rupture of membranes and hyperemesis.

Review of Physical Environment – OAR 333-077-0220

Barb Atkins, Plans Examiner for Facility Planning and Safety, provided an overview of the Physical Environment rule which was initially drafted using the Facility Guidelines Institute requirements. Concerns were registered by the RAC at the October 16, 2019 RAC meeting and it was suggested that the program consider the Commission for the Accreditation of Birth Centers (CABC), indicators of compliance with standards for birth centers. A cross walk of other adopted Oregon code requirements compared to the CABC standards was created and a new proposed rule suggested. The cross walk and new proposed rule were shared at the November 22, 2019 RAC meeting and RAC members were asked to provide comments via E-mail by January 10, 2020.

The new document that includes comments shared by RAC members on the new proposal was sent electronically on October 18, 2021 and the RAC proceeded to review the document.

Discussion:

- Page 1, row 1: Question was raised by RAC member regarding the classification of ambulatory care. Staff responded that under the 2019 Oregon Building Code, a birth center would be classified as an outpatient clinic, essentially meaning that the birthing person is capable of self-preservation at any time – if the person needed to, they could evacuate on their own without assistance (e.g., fire, fire alarm, etc.) compared to a hospital where a patient may be under anesthesia. NFPA classification of Ambulatory Care Facility was briefly discussed noting the differences (may not be capable of self-preservation due to anesthesia or procedures).
    - Staff clarified that the proposed rule is if someone is building a new birth center or if a significant remodel were occurring on an existing birth center. Existing birth centers have been approved under a previous code and do not need to comply with this new standard unless a significant renovation is planned (50% or more of space is going to be remodeled). It was noted that if someone wants to convert a house into a birthing center, a house is considered a residential occupancy, however, when using the house to run a business then federal compliance comes into play (e.g., accessibility, wheelchairs, discrimination laws, etc. and becomes a business occupancy.)
- Page 1, row 3: Question was raised by RAC member regarding minimum clearance for hallways, stairs, doors, etc. A birth center does not need further specifications than a clinic would. It was noted that a birth center is more like an outpatient clinic versus an ambulatory

surgical center. Staff noted the requirement for the 36" wide hallway is no more stringent than any outpatient clinic under review.

- Page 2, row 1: Staff noted comment previously provided by RAC member regarding elevators. It was noted that the program is not requiring elevators, rather providing a "heads-up" on what Oregon Building Codes require. Multi-story facilities wishing to serve laboring persons on the 2nd or 3rd floor, Oregon Building codes may require an elevator not the Oregon Health Authority. It was asked whether giving this 'heads-up' is necessary and the birthing center would need to rely on its design team to be aware of local building codes.
- Page 2, row 8: RAC member asked what is reasoning for requiring GFCI protection in outlets within 6 feet of other water source. If GFCI is on one circuit, why would multiple GFCIs be necessary? Staff noted that in a kitchen, if the first electrical circuit is GFCI protected, then each additional outlet is also protected. RAC member asked what is the benefit given the cost? Staff noted that they will research Oregon electrical code and will consider changing the rule language to reflect that the first outlet in a chain of outlets must be GFCI.
- Page 3, row 1: RAC member noted concern about the prohibition of extension cords when the state requires back-up support in case of power outage. When using generators for back-up support, extension cords are used. Also, a computer that is not a laptop will often have a surge protector which would also be an extension cord. Staff noted that 'relocatable power taps' (surge protectors) are allowed as long as they are off the floor and mounted to a wall at least 4" off the floor with non-permanent mounting (such as Velcro). Extension cords create tripping hazards to a laboring person and the prohibition is a safety precaution. Emergency preparedness trumps rules and as such use of a generator and extension cord is understandable. Staff indicated that clarification will be considered for rule.
- Page 3, row 2: Staff asked RAC for input on retaining term 'adequate lighting.' It was previously recommended that 'adequate lighting' be changed to "a minimum of ½ foot candle." Staff noted that this may create a hardship for a birthing center if a footcandle measurement is required as the center would need to submit photometric plans. Leaving the language vague may be best.
    - RAC member noted that the recommendation for foot candle came from residential lighting and was fine with 'adequate lighting.'
- Page 3, row 4: Staff shared previous comment from RAC member regarding infant identity. Staff indicated that per the CABC standards, provisions for infant security are required and may include but not limited to: "windows in birthing area have locks, birthing area access is regulated, infants are not separated from parents' area, there is no designated nursery area separate from the mother's care area, *there is a method for assuring infant identity such as Identification bracelets, foot printing, or other method*."
    - RAC member asked if any birth center does foot printing. The baby is not going to leave a client unless being transferred to hospital.
    - RAC member via chat indicated that hospitals no longer do foot printing for identification.
    - RAC asked whether any birth center is doing anything to identify newborn and requested that the identity proposal be removed from the rule.
    - RAC member echoed comment above and noted that in a birth center mom and baby are never separated. It is not common practice to do bracelets and is not necessary. It was noted that visitor logs are used when someone enters or leaves the facility and may be something to consider.

- RAC member stated that a safety plan should be implemented by a birth center and could include things like doors that are locked.

- Page 4, rows 2 and 3: Staff noted use of term "adequate space" and inquired whether more specificity should be considered. RAC member had previously stated concerns about the initial proposal specifying 7 feet in any plan dimension. Staff noted that the 7-foot reference is an Oregon Building Code requirement.
- Page 6, row 2: Staff noted previous concern registered by RAC member regarding requirement for a handwash station in each birth room. It was noted that CABC standards state, "Sufficient, convenient sink locations for all staff, clients and families, *including in birth rooms."* Staff noted that hand washing should occur in rooms where patient care is provided without touching a door.
    - RAC member asked what is considered the birthing room. Staff responded that the birth room is the room with a bed or a tub without having to access any door. The proposed rule would mean the handwash station must be located inside the room and viewable by the birthing person in the bed. RAC member responded that this would pose a problem and noted procedures such as handwashing before entering a room, use of gloves, doors to restrooms remaining ajar, cleaning procedures, etc. RAC member asked what is the benefit when no other clients will be in the area?
    - RAC member via chat agreed that this would be hard for birth centers moving forward.
    - RAC member noted that in a private birth suite, both clients and staff would have access to sink to wash hands without having to open or close a door. The door stays open all the time even when the birthing person is on the toilet so staff can monitor. Having a separate handwash station would be very challenging. It was further noted that foaming hand sanitizer is also available and would allow for hand sanitation.
    - RAC member suggested adding to rule having a hand sanitation station in the room if there is a door left open so that the providers can wash hands if needed and would be adequate. This would make it less of an obstacle for small birth centers or rural birth centers.
    - Staff indicated that they would consider the following: 1) In renovation projects when it is unattainable to provide a hand wash station in the patient room, it shall be provided in the toilet room or 2) not require a hand wash station in the birthing room but instead require an alcohol-based hand rub dispenser. Staff asked RAC to consider making it a requirement for new construction. RAC member responded that required for new construction would be reasonable; but would be challenging for persons renovating an old home. Staff noted the following language for consideration: In new construction a hand wash station shall be provided in the birthing room. In renovations and remodels of existing built environments, a hand sanitation dispenser with alcohol-based hand rub shall be provided at a minimum. RAC members concurred. One RAC member suggested that the language be for new construction, 'a hand wash sink or hand sanitation dispenser.'

ACTION: Staff will consider the following: 1) Removing reference to Oregon building code requirements for an elevator; 2) Research information on Oregon electrical code and removing reference to GFCI requirements in ***all* electrical outlets within 6 ft of water source; 3) Clarifying use of extension cords in an emergency while using generator; 4)**

Removing requirement for infant identification; and 5) revising requirement for hand wash station for remodel or renovation.

Wrap Up
RAC members agreed to continue discussion on physical environment at the November meeting. Next meeting is scheduled for November 29th at 10:00 a.m.

RAC adjourned at: 4:07 p.m.