PUBLIC HEALTH DIVISION
Office of Health Care Regulation and Quality Improvement
Kate Brown, Governor

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Birthing Center RAC
November 22, 2019
9:00 – Noon; Room 177

RAC MEMBER ATTENDEES	
Silke Akerson	Oregon Midwifery Council
Kaylyn Anderson (phone)	Consumer
Karen DeWitt	Oregon Association of Naturopathic Physicians
Laura Erickson	Alma Midwifery
Colleen Forbes	Board of Direct Entry Midwifery
Jennifer Gallardo	Andaluz Birthing center
Hermine Hayes-Klein	Oregon Association of Birthing centers
Ruby Jason	Oregon State Board of Nursing
Desiree LeFave	Bella Vie Birthing center
Cat Livingston	OHA-Health Evidence Review Commission
Meredith Mance	Aurora Birthing center
Danielle Meyer	Oregon Association of Hospitals and Health Systems
Margaret Porter	Bella Vie Birthing center
Stefanie Rogers (phone)	Providence
Anna Stiefvater	OHA-Public Health, Maternal & Child Health
Alice Taylor	American Association of Birthing centers
Michele Zimmerman-Pike	American College of Nurse Midwives
OTHER INTERESTED PARTY ATTENDEES	
Debbie Cowart (phone)	Growing Family Birthing center
Jody Davis	Public
Kelsie Fisher	Public
Sharron Fuchs	Public
Jason Gingerich (phone)	OHA-HERC
Lindsey Lincoln (phone)	Growing Family Birthing Center
Kailia Wray (phone)	Public
Allison Fonse (phone)	Public
OHA PHD HCRQI Staff	
Barbara Atkins	Plans Examiner; Facility Planning and Safety
Mellony Bernal	Administrative Rules and Legislative Policy Analyst
Anna Davis	Survey and Certification Manager; Health Facility Licensing & Certification
Rebecca Long	Paramedic/Health Educator; EMS and Trauma Systems
Dana Selover	Section Manager

Welcome
M. Bernal opened meeting and RAC members and public introduced themselves.

October 16, 2019 - Birthing Center RAC meeting notes
D. Selover asked if there were any comments on the October meeting notes. RAC members had no comments. D. Selover reminded RAC members that action items are being tracked and responses to action items will be shared at a future meeting.

NOTE – Clarifying statements for these November minutes were submitted by a RAC member at the January 24, 2020 BC RAC meeting. These comments are attached at the end of this document for reference.

Overview

D. Selover provided an overview of the purpose of today's meeting which is to review the risk factor tables. D. Selover reminded RAC members where references to the risk factor tables were made in rule and asked the RAC to think about what the risk factor tables mean for birthing centers and not individual providers. A birthing center may be staffed by several different providers, so while there are other risk factor discussions taking place for purposes of direct entry midwives and Medicaid payment, the risk factors for purposes of this RAC need to be considered as it relates to the facility and how those factors may apply to other types of providers, including the type of equipment that can be used in these facilities, extra staff available, etc.

Risk factor tables are referenced in the following rule locations:

1) Policies and procedures (0090) which requires birthing centers to have policies for purposes of assessing risk status; referral and transfer and consultation;
2) Client care services (0100) for purposes of requiring consultation if certain risk factors are present;
3) Admission and discharge (0110) for purposes of excluding clients from admission or requiring discharge if a client meets specified risk factors; and
4) Client transfer (0120) for risk factors that warrant a transfer.

It was noted that the current risk factor tables are specific to risks that are present at time of or prior to admission, and that occur during intrapartum and postpartum care.

Staff remarked that the purpose of these tables is to ensure safety and reduce risks in an out-of-hospital (OOH) setting and clearly identify factors that are not considered low risk given the definition of freestanding birthing center in ORS 442.015.

RAC member expressed concern that the revised tables were structured to align with the Health Evidence Review Commission (HERC) and suggested there is no safety data to support such a drastic change. Since implementing the HERC criteria for Medicaid patients, RAC member suggested there was a 75% drop in OOH births for clients covered by OHP. If similar risk factors are adopted for all women, most women will be excluded from receiving services in a birthing center. RAC member indicated that the HERC criteria may be reasonable for Medicaid to decide

coverage, but based on discussions with midwives and patients, it has not been successful overall. RAC member added that women feel they have been discriminated against, there is an increase in expenses, and reduction in access, etc. with no change in actual outcomes.

D. Selover noted that these rules may need to wait until after the HERC and Board of Direct Entry Midwives have completed their work and consider how the guidance changes. Given the HERC's process and review structure, it was determined that the Public Health Division would model those risk factors for initial rule discussions.

C. Livingston noted that when HERC started its process, it was based on other countries and systems that have very high quality out-of-birth practices with excellent outcomes (e.g. United Kingdom and Netherlands). A key priority of the state is to keep women safe and have better outcomes. Additional follow-up will be needed to investigate the data that suggests a 75% reduction in access.

RAC member asked whether there is a problem that even needs to be solved or are the revisions being made just to update for alignment? It was noted that making sure OOH birth is safe for women is the highest priority and to ensure that OOH births offered to women on Medicaid is offered in the safest, possible way. The risk criteria proposed reflect that intent.

RAC member remarked that it is great that the Public Health Division is updating the risk factor tables for the birthing centers but has serious concerns about the process:

- The HERC does not set the scope of practice for any provider type and the HERC guidelines are not considered the scope of practice for any provider type.
- The HERC guidelines do not dictate what hospitals or other facility types can provide.
- The HERC guidelines are only coverage guidance for persons who are covered by Medicaid and other boards and insurers can use them to inform their process.
- The efforts to apply the HERC guidelines to Public Health Division rules, the Board of Direct Entry Midwifery scope of practice and other processes, is irregular and is not the way the HERC is used for other provider or facility types and is strongly objected to.
- The HERC is a great process to look at vetted research about specific categories.
- It is not appropriate to consider the DEM rules unless the RAC also considers the Board of Naturopathic Physicians rules and Certified Nurse Midwife rules given the provider types that function in licensed birthing centers. These providers are expected to follow the standards of their professions.
- If looking at standards, it would be more appropriate to use the American Association of Birthing centers standards which are equally applicable to all three provider types and specifically to this setting.

RAC member responded to comment that HERC guidance was developed using models from other countries that have very high-quality OOH birth practices with excellent outcomes with additional concerns.

RAC member suggested that the Netherlands have always had a system where healthy women give birth at home with midwives and that a hospital is a back-up and they have always had better outcomes than the United States. Further, what makes an OOH birth safe in another country is integration.

RAC member added that the list of Obstetric Indications (LOI) is used in the Netherland. The LOI designates the most appropriate care provider for women with defined medical or obstetric conditions and is updated on a regular basis. It is always implemented based on the woman's informed consent and refusal. It is never used to prescribe what a woman must do, but rather as a source of information which is how the risk factors should be used here.

D. Selover remarked that the OHA and RAC are not arguing about the rights of individuals, but rather having a conversation about how to apply the statutory definition of a freestanding birthing center licensed primarily for the purpose of performing low risk deliveries.

RAC member shared concern that the HERC tables are for Oregon Health Plan insurance coverage which is not the same as evidence-based and best practice for a provider. To equate that they are the same is a disservice. It was suggested that the evidence used for the tables is not up-to-date and doesn't reflect more current evidence on topics. If safety is the intent, then current evidence needs to be used.

C. Livingston remarked that the HERC is actively reviewing up-to-date evidence. The HERC review process and all evidence used is open and posted for everyone to consider. Public meetings and public comment are actively sought during the HERC process.

It was noted that the PHD may need to delay in filing rules to consider the additional evidence gathered.

RAC member shared that there is more to the story than just the evidence reviewed such as additional factors. Women understand the risks involved and should not have their choice taken away and taking this away may lead to increased deaths.

RAC member suggested that the HERC does not look at coverage for interventions that happen in the hospital that are not evidenced based that lead women to choose a community birth or delivery at a birthing center. If a hospital bans vaginal birth after cesarean (VBACs) then women have a choice to go to a hospital for another C-section or go to a birthing center or have a home birth. If a birthing center can’t attend a woman having a VBAC then the choice may be an unassisted VBAC delivery at home. Many interventions that happen in the hospital are not evidenced based and that is what motivates a woman's choice to seek an OOH birth.

RAC member suggested that there is a maternity care crisis in Oregon and these discussions are very important for women's health. RAC member asked whether the HERC looked at the Strong Start data – an initiative funded by the Centers for Medicare and Medicaid Services aimed to reduce preterm births and improve outcomes.

C. Livingston responded that at the time of the initial drafting of guidance, the Strong Start study had not completed its findings. It is now being reviewed and will be considered in the review cycle that is currently being conducted. The study does not meet the inclusion criteria because it is not comparative, however, it is being considered for possible inclusion.

RAC member remarked that while OHA's intention to align with the HERC is understood, over the past five years, the data suggests that there are fewer low-risk women giving birth in birthing centers, when there is very strong data that more low risk women need to be encouraged to have this option.

RAC commented that women are choosing to have unattended deliveries because of the current guidance in place. A policy cannot be created that will push women to have unattended births when there is not strong data that indicates poorer outcomes.

RAC member stated that most research relevant to OOH birth outcomes does not meet the HERC study criteria (MANA Stats studies, Strong Start study, etc.) Most studies around birth outcomes are observational and are not considered by the HERC but should be considered in this process.

RAC member suggested that there are excellent birth outcomes in OOH births in Oregon. From 2015, 2016, 2017 and preliminary data for 2018 data, the perinatal mortality data for midwife attended planned OOH births in Oregon is less than 1 per 1,000; and is comparable to countries such as the Netherlands and the United Kingdom.

RAC member remarked that the Oregon data based on the Snowden study did show an increase in morbidity and mortality for infants with an OOH birth. Reducing maternal morbidity and mortality is very important but reducing the same for the infant is also important.

RAC member responded that the Snowden study data is from 2012 and 2013 which did show an increased risk of perinatal mortality for babies born in Oregon in an OOH setting.

RAC member commented that in response to that study, a quality improvement program was developed to address issues. Current data shows that perinatal mortality at OOH births is now lower than for planned hospital births. Midwifery care and midwifery responses to concerns is what has made a difference.

RAC member noted that the Oregon State Board of Nursing (OSBN) is seeing more and more Certified Nurse Midwifes graduate from out-of-state (OOS) programs that do not supervise or oversee students; have unlimited seating so there is no faculty to student ratio; students must find their own preceptor; and students can deliver babies unsupervised by the preceptor.
Discussion:

- The OSBN is concerned about the number of cases, public complaints and access to qualified providers.
- The OSBN does not have authority over the OOS education programs.

- There is concern about the variation in quality of care. Clinicians are not of equal caliber and thus risk factor tables may be necessary to clarify standards;
- The rights of the infant must also be considered.

RAC member shared that there are national organizations that have birthing center standards that are evidenced-based which should be enough. Additional standards should not be necessary. RAC member noted a study that indicated that a VBAC is safe for women with one cesarean, there were 0 per 1000 postpartum deaths at birthing centers.

RAC member responded to concerns shared about rights to infants. Discussion and comments from RAC members:

- If there is evidence that any OOH neonatal loss is related to a risk factor that is missing from a previous table, then that is evidence that should be considered;
- Authors of Snowden study indicated that there should be a focus on integration in order to eliminate disparities;
- Midwives do not have the power to change or improve integration (which means receiving transfer). Midwives do not have the power to get physicians to cooperate with them during prenatal care;
- If the state really wants to improve perinatal outcomes, it should require integration;
- Everyone is looking out for the baby and everyone is concerned about outcomes. When looking at decision making, the mother is the most concerned and vested in the outcome of a birth. Women are making choices based on best intentions and knowledge.

D. Selover noted that a mother's choice is based on the best information available to her. It's not about doubting the woman in making the decision, it's about the information that the woman receives and how that may or may not be influenced. It's important that when informed consent occurs, that it is standardized and fully comprehensive. A woman should have all the information she needs. Discussion and comments from RAC members:

- Standardized information for specific risk factors would be supported.
- Concern was raised about the manipulation of information (in both directions) in determining whether the information provided was adequate to make an informed choice.
- In order to make a risk analysis, a woman must have both the short-term perinatal risk as well as any long-term risk to themselves which is often systematically undervalued (e.g. cesarean surgery).
- Many women have already done a lot of research on risks and are thus making a more informed decision.

RAC member remarked that from a consumer standpoint of the safety of the mother and child, the woman is trusting that the provider has the best interest of the mother and child in mind and that the provider has the most current evidence-based data.

In response to concerns about OOS, Certified Nurse Midwife education programs, a RAC member shared that the Commission on Midwifery Education must accredit all midwifery education

programs which sets forth the standards that programs must meet in order to offer those programs. Some OOS programs may be more stringent than in-state and requiring students to get their own preceptor may help with assertiveness and finding a good fit which may influence the care given in the future. Further comments from RAC members:

- Question was asked whether this problem was in birthing centers only or systemic. Response was it's systemic and has nothing to do with the facility type.
- License means the individual has met a minimum set of standards and the public trusts them to be safe.
- Not all advanced practice nurses understand their scope.
- There are many great OOS programs; the OSBN is just raising awareness of concerns received.
- Patients receiving information and patients being informed are completely different and some providers may not understand.
- The OSBN is seeing more and more scope creep with less and less knowledge about what the scope of practice really is.

RAC member noted that the amount of informed choice in a birthing center is profoundly different than what is offered in other health facilities.

D. Selover shared that the RAC needs to consider the following and asked what order to discuss these issues:

1) Risk factor table content and ease of use;
2) How tables compare to the past and other guidance;
3) How to apply consultation versus exclusion and transfer. There is not enough clarity on the process. The DEM has really good information in their rules.

RAC members voted to review the risk factor tables. D. Selover noted that this RAC does not have the structure to look at data in a nuanced way to determine whether the data is good or bad. This is why the program is referring to the HERC.

C. Livingston noted that the HERC has reviewed all comparative literature and guidelines including the AABC, UK, Netherlands, etc.

RAC member noted that the intent is not to introduce new studies about specific things that fall under the HERC. The HERC has done great work in accumulating relevant studies. The main issue is that the HERC does not consider as high-quality evidence, the vast majority of research that specifically relates to birthing center births, home births or OOH births generally in the U.S. Funding for research in the U.S. for midwifery and OOH births is marginalized, and comparative studies between OOH births and in-hospital births have not been funded. It was further noted that, it's not because the research that is happening is not useful. It is very useful to look at studies that look at tens of thousands of OOH births. These additional studies are relevant for purposes of birthing center rules. The state cannot hold to a comparative study standard when there is no willingness to look at what is actually happening in planned OOH births.

C. Livingston noted that the HERC included evidence from other countries which is very supportive of OOH births. Comparative data is needed to understand outcomes otherwise there are issues of bias. Both US data and out-of-country data was considered.

RAC member inquired whether there was agreement that information such as MANA stat data specific to Oregon births and outcomes is relevant? Comments from RAC members included:

- Oregon Midwifery Council looks at both Oregon and national MANA stat data which should be considered, along with Center for Health Statistics data.
- Need to look at maximum safety balanced with informed choice.
- Need to figure out how to consider the data.

Risk Factor Table 1 – Exclusions at Admission

D. Selover opened discussion on the risk factor tables noting that the RAC will review the lists and identify factors that RAC members agree should remain on the list, or those factors where additional data or additional conversation is needed.

Table 1 - Exclusions at admission is meant to identify women that come to the birthing center at various phases of pregnancy and present with a risk factor that will exclude them from receiving care.

MATERNAL HISTORY	RAC RECOMMENDATION
Cesarean section or other hysterotomy	**DEFER DISCUSSION**
Eclampsia/Pre-eclampsia requiring preterm birth/HELLP Syndrome	**DEFER DISCUSSION**
• RAC member remarked that Eclampsia and Pre-eclampsia are more common in the first pregnancy and it shouldn't be assumed that it will happen again. • RAC member suggested that anything being added (that is not currently in place with existing rules) decreases access to birthing centers and should not be considered unless Oregon data suggests otherwise. • RAC member noted that these indicators were not previously in rule because a birthing center could take a client who had a previous pregnancy where they had pre-eclampsia or eclampsia and monitor them for possible future exclusion. ○ NOTE - CURRENT OAR TABLE 1 – ADMISSION – states: "ABSOLUTE RISK FACTORS – If present at the time of admission to the birthing center, the following conditions would necessitate transfer of the client to a higher level of care: - Eclampsia; preeclampsia with lab abnormalities.	

• RAC member remarked that any decisions made should not limit rural birthing centers who might be providing prenatal care even if a client plans to have a hospital birth. Example was provided of a birthing center taking care of clients, for example, with twin gestations. Clients were planning to deliver in the hospital but had access issues with getting prenatal care. Nothing should prevent any birthing center from providing prenatal care. • Staff noted that based on current rules and risk factor tables, it's not just exclusion from birth care in a birthing center, it would include pregnancy care. Pregnancy care could be offered in a separate, distinct space from the center. It was noted that based on previous RAC discussions, one of the action items was to allow a birthing center to provide prenatal care even in instances where a client may have certain risk factors. This action item is under consideration. • RAC member remarked that it's completely appropriate for a midwife working in a birthing center to provide care for someone with a history of eclampsia, HELLP syndrome, or preeclampsia requiring preterm birth. Risk factors have warning signs that would allow a provider to refer or transfer as necessary. • RAC member remarked that women can make an informed choice, if they're given data and proper information. Additionally, a patient can be appropriately transferred to the hospital in time and potentially still have a better outcome given advantages to care in the midwifery setting. • It was noted that this is a HERC exclusion for OOH birth services and is a risk factor that is universally excluded for OOH birth. • RAC member suggested that eclampsia, preeclampsia and HELLP syndrome are manageable risks as opposed to absolute risk factors as a maternal history element not as a current pregnancy complication. • RAC member suggested that these factors might make more sense as requiring a consultation with a physician for purposes of prenatal care. In rural areas, pregnant women are frequently cared for in communities that are planning to birth at OHSU which is a multi-hour trip. These clients intend to go see a physician and are in consultation with a physician during their prenatal care. • RAC member remarked that each pregnancy be thought of separately unless it's something like an RH factor that lasts forever. The conditions under consideration are not lifelong chronic conditions. They're acute conditions that come up with a pregnancy. Women should be watched more closely, additional labs considered including more frequent testing, and require consultation with an obstetrician, but they shouldn't be excluded from care. • RAC member shared that women could receive co-care where they're established with a doctor, and in communication with the doctor during prenatal care because it is just not possible for her to get the care and	

attention she needs from a physician, as often as may be needed for whatever reason. • RAC member indicated that an integrated care system is a great approach where the midwife is collaborating with maternal/fetal medicine specialist and obstetricians that are willing to provide collaborative care. It's very common for women who have historical factors or current pregnancy complications, to drive several hours to see an OB or specialist, and alternate care visits with a midwife at a birthing center. Birthing centers should not be excluded from providing care under those circumstances. • RAC member suggested that a high-risk birth is one for which a risk has actually manifested. Otherwise, there is an attenuated risk of becoming at risk and the risk of a future risk is being used to try and deny access. Midwives have shared that that they have the training and skills to identify the risks that have the potential to manifest. If the fear is that providers lack the skills or training or ability to make those risk analyses, the place to deal with that is through the provider's licensing board. Rules should not be written that assume practitioners do not know how to do their job under their license. • D. Selover remarked that the program is looking at the rules from a perspective of ensuring safety not denying access. RAC member responded that not allowing a woman to birth in a birthing center, when the woman has been informed and continues to choose an OOH birth, is patient abandonment and not about safety. • RAC member clarified that the revised DEM rules allow only supportive care if a pregnant woman meets exclusion criteria or indication for transfer. Supportive care includes nutritional counseling, emotional support, and social development. This may occur while the woman is receiving clinical care from a physician. If the condition resolves then the midwife can resume full responsibility of care. A collaborative care model would be ideal and is what makes OOH birth safe in other countries. • RAC member suggested that a history of HELLP syndrome needs to be an exclusion factor.	
4th degree laceration without satisfactory functional recovery	**RETAIN**
• RAC member remarked that this factor should remain as an exclusion • RAC members agreed.	
Retained placenta requiring surgical removal	**REVISE and RETAIN**
• RAC member remarked that this factor should remain as an exclusion • RAC member suggested that this statement is not descriptive enough and should be revised to reference accreta. • It was noted that women with a history of placental accreta are at increased risk for the same condition in subsequent pregnancies. RAC member reiterated a woman's right to choose to continue to receive care	

and questioned where the cut-off line is for acceptable risk (e.g. percent risk of occurrence). RAC member suggested this should not be an absolute exclusion if a woman chooses to continue to receive care.	
Uterine rupture	**RETAIN**
• RAC member suggested this factor remain as an exclusion • RAC members agreed.	

PREVIOUS FETAL HISTORY	**RAC RECOMMENDATION**
Neonatal encephalopathy	**DEFER DISCUSSION**
• RAC member suggested that the terminology is not accurate enough and should be changed to HIE (hypoxic-ischemic encephalopathy). • RAC member expressed concern that neonatal encephalopathy is result of various events that are not necessarily recurrent.	
Stillbirth or neonatal death (unexplained) or previous death related to intrapartum difficulty	**REVISE and RETAIN**
• RAC member noted that many religious patients choose not to interfere with a pregnancy while the fetus is still inside and also choose not to have an autopsy. Pushing these clients to a hospital discriminates against their freedom of religion. • RAC member noted that religious clients frequently do not get an anatomy screen ultrasound, wouldn't have an autopsy, and a birthing center would not have evidence that something was 'unexplained by anomaly.' • RAC member indicated support of retaining 'stillbirth related to previous intrapartum difficulty.' • RAC member remarked that a lot of women choose OOH birth if they have a previous loss in a hospital. Retaining 'stillbirth related to previous intrapartum difficulty' may lead to outcry from consumers. • RAC member echoed that there are a lot of clients that inherently distrust hospitals and retaining stillbirth may result in many women having unassisted births. • Majority of RAC members voted to keep 'stillbirth related to intrapartum difficulty' as an exclusion factor.	
Placental abruption with adverse outcome	**RETAIN**
• RAC members agreed to retain as an exclusion factor.	

Risk factor discussion ended given time. HCRQI staff will consider the best method to facilitate future discussion including voting mechanism.

ACTION: HCRQI staff will consider a different process for use in future meetings for discussing and voting on risk factors in Tables I through III.
Follow-up on FGI Discussion
Based on feedback received from RAC members, staff reconsidered the physical environment requirements for birthing centers. A crosswalk was created comparing current Oregon Structural Specialty Code (OSSC), American National Standards Institute (ANSI), and National Fire Protection Association (NFPA) requirements alongside the Commission for Accreditation of Birth Centers (CABC) indicators of compliance and the Facility Guidelines Institute recommendations. A copy of the revised proposal was shared with the RAC and RAC members were asked to review the revised proposal and send concrete feedback to Mellony Bernal and Barbara Atkins. RAC members were also asked to specifically consider references that refer to "adequate space" or "adequate storage" which is unenforceable. RAC members were asked to submit suggested criteria for those references.
ACTION: Comments from RAC members on the proposed revised physical environment standards are **due by January 10th, 2020.** (Reference email sent on December 3, 2019).
Next Steps
Next meeting is scheduled for January 24, 2020 at 9:00 a.m.
ACTION: Staff will send out an e-mail with additional meeting poll links.

Meeting adjourned at 12:00 p.m.

Memorandum

To: Mellony Bernal, Oregon Health Authority
From: Hermine Hayes-Klein, JD on behalf of Oregon Association of Birth Centers
Re: January 24, 2020 RAC Meeting for Birth Center Rules: Corrections to Minutes from November 22, 2019 RAC Meeting
Date: January 27, 2020

At the beginning of the January 24, 2020 OHA RAC Meeting for Oregon Birth Center Rules, I offered the following clarifications regarding the November 22, 2019 meeting minutes. Despite these clarifications, the minutes have been consistently thorough and excellent, and that they had generally captured robust exchanges with accuracy.

1. P.2: "Since implementing the HERC criteria for Medicaid patients, RAC member suggested there was a 75% drop in OOH births for clients covered by OHP."
    a. Clarification: The context of this paragraph suggests that the 75% drop in OHP clients able to access OOH birth is due to OHA's refusal to cover women with risk factors included in HERC. The point that I heard being made at that meeting (by some of the OOH providers, I believe) was that the dramatic decline in access to OOH midwifery services, since implementation of HERC, is due as much to discrimination and bias in OHA's OOH prior authorization process, as to the way OHA is using HERC to deny coverage for OOH births that are within the birth center and the providers' legal scope of practice. See, e.g., the Report from the Out of Hospital Birth Prior Authorization Review Workshop, 9/2018.

2. P.3: "RAC member suggested that the Netherlands have always had a system where healthy women give birth at home with midwives, and that a hospital is backup and they have always had better outcomes than the U.S. Further, what makes an OOH birth safe in another country is integration."
    a. Clarification: I made this point in response to Cat Livingston's remark that many of the risk factors in the HERC Guidelines were included in the guidelines for transfer in nations with the best outcomes for OOH birth, and she cited the Netherlands and the UK. At that point, I didn't suggest, but accurately stated that the Netherlands' healthcare system has always considered childbirth to be a normal physiological event with the potential to become a medical event, rather than a medical event by definition, and have treated it as appropriate for women to give birth at home with midwives, and to save doctors and hospitals for the event that medical treatment is actually needed. I stated that Dutch perinatal and maternal outcomes over the last century have been better than ours, and disprove the American cultural belief that the safest place for normal birth is at the hospital under the care of physicians. Studies out of the Netherlands, the UK and Canada indicate that, when OOH birth is integrated, it has the same short-term perinatal outcomes as planned hospital birth, but much healthier long-term outcomes for mother and baby. The thing that makes OOH birth safe in nations like the Netherlands, UK and Canada is integration and continuity of care, not guidelines imposed as rules restricting access to midwifery care. The authors of the Oregon

Snowden study expressed this point publicly, stating that the conclusions from their study should not be to blame midwives or to restrict access to OOH birth, but to improve integration and continuity of care.

b. My main point was that it is important to understand that all of the nations with safe OOH maternity services treat their guidelines for transfer from midwifery to medical care as intersectional with the woman's right of informed choice, and the provider's bioethical duty of non-abandonment. Women are provided with midwifery care if they refuse medical care, and ensured secure access to medical services in the event they come to need or choose them. Secure integration and access to care should be the focus of OHA's effort to optimize safety for OOH birth.

3. P.4: "D. Selover remarked that the OHA and the RAC are not arguing about the rights of individuals, but rather having a conversation about how to apply the statutory definition of a freestanding birthing center licensed primarily for the purpose of performing low risk deliveries."
    a. Clarification: My response to Dana's point here didn't make it into the minutes, but I think it's important:
        i. This committee is meeting to write the regulations that will affect which women can or cannot give birth at a birth center, given the medical risk factor Tables that Oregon uses to define access to birth center care. Under Oregon birth center rules, licensed birth centers cannot provide services to women with the risk factors listed on the Tables. The existing Tables were presumably drafted with the idea that they would keep women and babies "safe." The drafters of these proposed rules presumably have data indicating that there is a safety gap that justifies adding many more risk factors to the Tables, and therefore excluding many more women from birth center care. This committee meeting is the time for OHA to present the evidence indicating that adding the new risk factors on the draft tables would actually serve the goal of "safety."
        i. However, while the purpose of the regulations is obviously to optimize public health and safety for the women who give birth in Oregon and their babies, it should go without saying that these regulations, which are laws, must be written in a way that anticipates, respects, and upholds the legal rights of the people affected by those rules. The Oregon Health Authority, and its agents and representatives, are the State. It is one thing for hospitals to routinely ignore and violate the legal rights of pregnant women, as they do by withholding healthcare support for vaginal birth, and offering only support for surgical delivery, to women with risk factors that they don't like or find inconvenient, like prior cesarean section. But the State of Oregon doesn't have that luxury. The State of Oregon has the obligation to respect and uphold its citizens' rights. That includes their rights to medical decision-making generally, and pregnant women's rights to make medical decisions on behalf of both themselves and their unborn babies, in particular.

ii. This committee has a choice, whether to write regulations that respect and uphold the reproductive, constitutional, and human rights of women in Oregon to make informed medical decisions, even if they make decisions that we personally would not make. Or this committee can erode those rights by drafting regulations that ignore women's rights to make the safest decision for themselves and their babies, and abandon care if they make certain decisions, with the result of diminished safety. Portland, Oregon should be a place where women's rights are not only remembered and recognized as relevant to the laws that affect them, but are protected and secure.

4. P.6: "Everyone is looking out for the baby and everyone is concerned about outcomes. When looking at decision-making, the mother is the most concerned and vested in the outcome of a birth. Women are making choices based on best intentions and knowledge."
    a. My point here didn't make it into the minutes:
        i. Everyone involved in a birth is making decisions on the basis of best intentions and knowledge, patient and providers. And no matter who is making the decision, sometimes babies do not survive childbirth. No matter how everybody involved may feel about the risks of a tragic outcome, no matter how scared anybody may be for the baby, there is no legal question about who has the right to make decisions for the baby, during pregnancy and childbirth. That person is the mother, the pregnant woman, because when she makes decisions for the baby, she is also making decisions about her own body. There is no law, in Oregon or federally, that has removed pregnant women from the class of people who get to make autonomous medical decisions. Therefore, any discussion of the rights and needs of the baby need to make clear for the minutes that legally, the rights of the infant are protected by respecting its mother, and her right to make decisions on both of their behalves. The rights, and needs, of the baby are not protected by bullying and coercing pregnant or birthing women into medical interventions that they don't want, in the names of "the rights of their unborn baby."

5. P.7: "RAC Member noted that the amount of informed choice in a birthing center is profoundly different than what is offered in other health facilities."
    a. By "profoundly different," the RAC member (not myself) was explaining that the informed consent/ choice process is far more thorough, detailed, meaningful, and frequent in birth centers than in other health facilities, because informed consent and patient autonomy are foundational to the midwifery model of care.

Thank You!