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Birthing Center Rule Advisory Committee
June 4, 2024
9:00 a.m. via Zoom

RAC MEMBER ATTENDEES	
Danielle Meyer	Hospital Association of Oregon
Desiree LeFave	Bella Vie Gentle Birth Center (Administrative)
Emilia Smith	Oregon Midwifery Council
Hermine Hayes-Klein	Oregon Association of Birth Centers
Karen DeWitt	Oregon Association of Naturopathic Physicians
Kaylyn Anderson	Consumer
Laura Erickson	Alma Midwifery Services
Lynette Pettibone	American Association of Birth Centers
Megan Coppock	Andaluz Waterbirth Center
Michelle Zimmerman-Pike	Oregon Affiliate of the American College of Nurse Midwives
Sarah Wickenhagen	Oregon State Board of Nursing
Wendy Smith	Legacy Emanual Medical Center
Willa Woodard Ervin	Rogue Birth Center

INVITED SUBJECT MATTER EXPERTS	
Carrie Duncan, CPM, LDM	Andaluz Waterbirth Center
Catherine Bailey, CPM, LDM	
Jen Kamel	VBAC Facts
Melissa (Missy) Cheyney, PhD, LDM	

OTHER INTERESTED PARTY ATTENDEES	
AlexAnn Westlake	Our Community Birth Center
Charlotte Clausen	Women's Care
Christina Clay	Public
Jeanne Savage	Trillium Community Health Plan
Laura Wiegand	Andaluz Waterbirth Center
Mary Engrav	CareOregon
Ray Gambrill	AllCare Health
Rebeckah Orton	Astoria Birth Center
Sharron Fuchs	Public

OHA Staff	
Anna Davis	PHD-Health Facility Licensing & Certification
Dana Selover	PHD-Health Care Regulation & Quality Improvement
Lacey Martinez	PHD-Health Facility Licensing & Certification
Mellony Bernal	PHD-Health Care Regulation & Quality Improvement
Rebecca Long	PHD-Emergency Medical Services & Trauma Systems Program
Samie Patnode	Health Licensing Office

Welcome and Overview

Mellony Bernal welcomed Birthing Center Rule Advisory Committee (RAC) members and other interested parties and reviewed housekeeping items.

- The purpose of this RAC meeting is to hear from invited guests about their professional experience and related information about the risks related to a vaginal birth after cesarean and possible safety measures that might be considered for the health and safety of the client.
- Participants were asked to enter their name, organization and whether they are a RAC member, member of public, or staff of Oregon Health Authority into the Chat.
- RAC members may choose to keep video on or off, however, if called upon to speak please turn video on. Members of the public are asked to keep video off for duration of meeting.
- Meeting is being recorded and all messages entered into the Chat are saved and subject to disclosure.
- Meeting minutes will be drafted and sent to RAC members and posted on the HFLC Rulemaking Activity website: https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/HEALTHCAREPROVIDERSFACILITIES/HEALTHCAREHEALTHCAREREGULATIONQUALITYIMPROVEMENT/Pages/proposedrules.aspx
- RAC meetings are not subject to public meetings law. Members of the public may attend but may not participate or offer public comment. A public hearing and written public comment period will be scheduled at a later time to obtain oral and written feedback from the public on final proposed rules. All information related to the public hearing and written comment deadline will be posted on the Rulemaking Activity web page.
- Interested parties will be notified about the public hearing and public comment period using our GovDelivery listserv. A link to sign-up for this listserv was shared: https://public.govdelivery.com/accounts/ORDHS/subscriber/new?qsp=ORDHS_16
- RAC members were asked to use the Chat function to indicate if they have a question or want to speak. Type the word “COMMENT” into the Chat and persons will be called upon to speak. Type the words “For the Record” or letters “FTR” and type out the information you wish to share. Persons who type For the Record/FTR will not be called upon to speak. Staff will try and call upon persons in the order they appear on the Chat.

Overview of Agenda

Dana Selover welcomed everyone and provided brief overview:

- RAC is wrapping up discussions relating to the overhaul of the Birthing Center administrative rules which will include being renumbered from OAR 333-076 to OAR 333-077.
- Rules have not been revised since 2006.
- The Rule Advisory Committee (RAC) has been meeting since 2019 and all meeting agendas and minutes are posted on the HFLC Rulemaking Activity webpage.

- This VBAC RAC meeting is the final discussion relating to risk factors. At the request of RAC members, VBAC subject matter experts in a birthing center setting have been invited to share their perspective and related information.
- This meeting is not a public hearing, nor a legislative hearing, and is not for purposes of taking formal testimony. Each invited presenter will have approximately 15 minutes to provide information from their perspective about VBACs in a birthing center. It was noted that one additional invitee contacted staff late, and if they are able to participate, time may be adjusted to accommodate. Questions and discussion will be held until after invitees have shared their information. D. Selover also requested that RAC members not use the Chat to comment on information shared by presenters until after all presenters have finished sharing.

Invited Subject Matter Experts on VBAC

D. Selover asked invitees to introduce themselves and provide information on their background.

Melissa (Missy) Cheyney, PhD

Dr. Cheney shared the following background information about herself:

- Professor of medical anthropology and reproductive health at Oregon State University;
- Midwife for 20 years (stopped practicing in 2020);
- Editor in chief of Birth Issues and Perinatal Care, one of the only journals that focuses on normal physiologic birth;
- Co-director of Uplift Lab, a research and reproductive equity laboratory at Oregon State University;
- Co-director of the Community Birth Data Registry (CBDR), an initiative through the Foundation for Healthcare Quality in Washington state, collecting pilot data on community births (home and birth center births) in the states of Washington and Oklahoma. The goal is to combine this data with the Perinatal Data Registry (PDR), developed by the American Association of Birthing Centers, so there is a national data set that can track all community birth outcomes;
- Chair of the Division of Research for the Midwives Alliance of North American (MANA) for 12 years, and during that time, wrote many articles relating to VBAC and birth outcomes in the community setting; and
- Co-director of the Quality and Maternal Newborn Care (QMNC) Alliance, a global alliance of researchers who study midwifery and physiologic birth around the world.

Dr. Cheyney noted she had three topics to cover:

1) Evidence that supports laboring after cesarean in the community setting, specifically in birth centers;
2) Importance of integration for making sure that outcomes in birth centers are as positive as possible; and
3) Autonomy and access.

Evidence

- In 2008, Dr. Cheney served on the National Academies of Science, Engineering, and Medicine, Birth Settings in America study, which was congressionally appointed to look at outcomes in the United States. One main conclusion is that increased access to nonsurgical options like labor after cesarean and external cephalic version is needed to help reduce the cesarean rate in the United States.
- Dr. Cheney was asked to serve in part due to the number of studies she has conducted using PDR data and MANAStats (which captures primarily home but also some birth center births data).
    - Study with over 47,000 pregnancies looked at outcomes by risk factors. The comparison group was multiples with no risk factors compared to individuals who had had a prior cesarean with and without another vaginal birth, gestational diabetes, breach, twins, etc.
        - The study found that the rate of success for labor after cesarean in the community setting is high. People with a prior vaginal birth and a prior cesarean had a 93 percent success rate. Individuals that had no prior vaginal birth had close to an 80 percent success rate. This helps to understand why people are wanting to attempt a labor after cesarean outside of the hospital.
        - Also found that most of the people who attempt an out-of-hospital birth for labor after cesarean have already had one vaginal birth (60 percent had already had one vaginal birth in the sample).
        - There were very low rates of individuals who had compounding risk factors.
        - In addition to laboring after cesarean, the study included other complications like gestational diabetes mellitus or post-dates, in those instances, most of the poor outcomes were actually concentrated in individuals who had additional risk factors on top of having a previously scarred uterus.
        - For persons who didn't have additional risk factors and where transfer was timely, the outcomes were really excellent.
- Dr. Cheyney noted that Oregon has been at the forefront and should be the model for a lot of other states in how VBACs are managed in a birth center setting, largely because there is a focus on additional risk factors, which has shown makes a difference in outcomes for VBAC but also because of the focus on autonomy and informed decision making.
    - In a large sample size VBAC study, poor outcomes were looked at closely.
        - One way to keep out-of-hospital VBAC safe as possible is early conservative transfer;
        - Making sure there were no other additional risk factors, or few other additional risk factors;
        - While plateaus (when labor is going along, plenty of contractions, but no change to cervix) are normal, in a previously scarred uterus, pressure from contractions is either going to help open the cervix or in some instance it affects the scar, and there is a need to pay close attention.
        - Reversals of station tended to predict poor outcomes.
        - In the absence of plateaus or reversals of station and keeping in mind risk factors and informed choice, outcomes actually look very good.

- Dr. Cheney indicated that she couldn't find any good evidence for restricting access in the birth center setting.

Integration

- Dr. Cheney indicated integration as being key. She noted that there's a lot written globally about systems that do too much too soon, and too little too late. The hospital-based system is often thought of as being a too much too soon system, and what we're looking for is the right amount, at the right time, and the right place.
- Birth center data shows that birth center midwives are able to identify when someone needs to be triaged to a higher level of care when a complication arises. With good risk selection, informed consent, respect for autonomy and triage to a higher level of care, when needed, in a collaborative manner, excellent outcomes are seen.
- In a study that mapped levels of integration across the United States, how integration of home, birth center birth, midwives into the larger system of hospital-based care on how outcomes were affected was looked at. Integration was the best predictor next to race on birth outcomes. Race was the biggest predictor of birth outcomes and second was level of integration.
- Recommendation would be not to restrict access to labor after cesarean in a birth center setting, but to focus on building relationships and integration across systems so there can be an appropriate and smooth transfer.
- There is a huge body of literature suggesting that midwives are well-placed to offer this kind of care in birth centers as well as in the hospital.

Autonomy and Access

- Dr. Cheney remarked that VBAC rates in the United States have remained low and quite stable. Since 2022, they are under 15 percent.
- In a project where people from across the nation were invited to talk about their experience of seeking VBAC care, it was found that people face enormous, extraordinary challenges in getting access to vaginal birth after cesarean.
    - People traveling long distances, including going to other states;
    - Sometimes having unassisted birth;
    - Giving birth at home sometimes with credentialed providers, sometimes not;
    - Giving birth in hotels in other states to get access to VBAC.
- Dr. Cheyney recommended against doing anything that restricts further access to VBAC outside of the hospital.
    - Looking at the American College of Obstetricians and Gynecologists statement on maternal autonomy, she indicated that they are unequivocal in their support for people's right to make decisions about their own body, and they say that while birthing people have to be given appropriate, complete information about risks, benefits, choices, the potential consequences of their choices, maternal autonomy can never be overridden even if there was clear evidence of potential fetal harm incurred by their choice.
- It was noted that in terms of access, access is really inequitably distributed. People choose birth centers for labor after cesarean because they can't always find a provider who is supportive or a hospital that will allow it.
- It was stated that in addition to just choosing a birth center because there is no hospital, there's also similarly alarming data on rates of mistreatment and inequity due to systemic

racism in the United States. Thus, it's understandable why people, especially people of color, might choose to give birth in birth center where they have a known number of carers. Every interaction in the hospital means a person may interact with someone who's incredibly supportive, loving compassionate, but persons may also face either explicit or implicit racism.

- In the 'Giving Voice to Mothers' study in 2019, privileged voices of under-served communities, with over 2,000 respondents to the survey:
  - One in six birthing people in the United States experienced some kind of mistreatment while giving birth in the hospital;
  - The rate for the community setting (home and birth center births) was 5% experienced mistreatment compared to 28.1% in the hospital.
  - Identities including race, ethnicity, and socioeconomic status also intersect, and it was found, for example, that women of color, who also had low socioeconomic status, had a 27% chance of experiencing some form of mistreatment. While white woman who had low socioeconomic status had about an 18% chance. There are intersecting identities that affect people's ability to access care.
- There is a lot of evidence that cesarean birth, especially if the birthing person feels it was unnecessary, can be extremely traumatic and is associated with post-traumatic stress syndrome. It's not appropriate for every person who gets pregnant again and is wanting to attempt a labor after cesarean to have to go back to a hospital that may be associated with that trauma.

Dr. Cheyney concluded her comments stating that attempts across the United States to restrict access to care in certain settings or to narrow the range of practice for midwives or to reduce choice for birthing people is motivated by a misplaced desire to protect people. Just not dying in birth or not having some kind of injury is a low bar – the floor, not the ceiling - of what we're trying to achieve. People should have not only a live, healthy baby and a healthy body, but also a positive experience going into parenting, from a position of power, support, compassion and, not one of victimization. In order to do that, there needs to be a full range of options open to birthing people in the United States.

Carrie Duncan, LDM

Carrie Duncan shared the following background information about herself:

- Midwife in the Portland area for over 23 years, and most of that time has been serving in a birth center setting.
- For the last two years, serving as the Midwife Director at Andaluz Water Birth Center.

C. Duncan noted that the Andaluz Waterbirth Center has a successful VBAC rate of about 89% with two additional successful VBACs in one day last week. They are proud of the success.

It was noted that the birth center uses a robust intake screening process and continued evaluation for comorbidities and compounding risk factors, as well as the current state guidelines and CABC guidelines, backed by an equally robust process for continued quality improvement. Peer review of serious and sentinel events are conducted both in community setting as well as professional setting by the Oregon Midwifery Council and the Commission for the Accreditation of Birth Centers. This is how Andaluz ensures that they are continuing to improve the quality of the care delivered, including compliance with regulatory guidelines, and

staying up to date with new shifts in the evidence. They are proud to use a shared decision making to honestly inform clients.

C. Duncan stated that clients choose Andaluz for their years of experience and expertise. Andaluz has a lot of experience and C. Duncan can speak to many years of serving VBAC clients which is something that people are looking for.

C. Duncan remarked that Andaluz's success rate of almost 90% is on par with the rest of the birth centers which tend to land around 90% on average and is why birthing persons are choosing birth centers for a trial labor of after cesarean. Most clients are choosing the birth center from a place of conservatism not to take extra risk:

- Clients are trying to avoid a medicalized induction, and want to avoid interventions such as Pitocin, misoprostol and induction.
- Clients want to labor biologically which minimizes their chance for uterine rupture and other complications.
- Clients want extra attention and one-on-one care; they want a smaller practice with more individualized attention.
- Clients want a relationship with their provider and continuity of care.
- Clients are more compliant with provider recommendations based on more attention paid to them.
- If risk factors are found, they are happy to go to the hospital and receive the care they need.

C. Duncan has served over 1,000 women in a birthing space, and VBACs are some of the most impassioned folks served. Regardless of the method of birth, the birth center is able to make a huge impact and has a high satisfaction rate among the people served. Even if a client ends up transferring for a repeat cesarean or for another reason, clients are still more satisfied with their birth because they were able to receive midwifery care with longer appointment times, more individualized attention, and better follow up. C. Duncan further stated that clients are less likely to have postpartum depression.

C. Duncan shared the concern that when choices are limited, services are pushed further underground (example VBAC). A story was shared of someone who traveled from a Southern state to come try for VBAC with Andaluz. Clients will not stop seeking the service, rather will travel farther and take bigger risks. There is evidence that people are choosing unassisted birth due to limited options and traveling long distances to receive care. There is then no continuity of care with a provider which has its own risks. People who are often traumatized by the experience will still seek the care that they deserve or seek the experience that they want, one way or another. Providing an avenue where individuals can have a well-informed, expert provider, individualized care, in a safe setting is the only ethical way to proceed and statistics have demonstrated that this is being done.

Catherine Bailey, LDM

Catherine Bailey shared the following background information about themself:

- Licensed midwife in Portland attending home births currently since 2011;
- Current president of the Oregon Midwifery Foundation focusing on giving grants to new midwives and student midwives who are black, indigenous, or people of color;
- Involved with the Oregon Midwifery Council for a long time and organized continuing education conferences for midwives for about 10 years.

C. Bailey shared that she has attended many VBAC births both at home and in the birth center setting, both as a student and as a licensed midwife and noted that they attended VBACs with Carrie Duncan as a student 12 and 13 years ago, has consulted with Melissa Chaney about more complex VBAC cases in the past, and has organized a CEU conference inviting Jen Kamel to come out to Oregon to speak to midwives. It's a reminder that midwives need community, and midwives need each other to keep their clients safe, they do not need more restriction.

It was stated that midwives should be allowed to attend VBAC births at birth centers. As a licensed midwife, C. Bailey has been practicing with the Oregon licensed direct entry midwifery (LDM) rules and has appreciated having those rules which are appropriate for keeping clients safe.

- Currently, the LDM rules state that licensed midwives can attend home birth or a birth center birth for clients who have had a previous C-section.
- Additional LDM regulations state clients with a history of four or more C-sections must be transferred; or clients with three C-sections without a previous successful vaginal birth.
- LDMs are not allowed to attend births where people have had a previous classical incision, T incision or other extensive transfundal surgery or a prior uterine rupture.
- LDMs are required to transfer care with any signs or symptoms of uterine rupture.
- LDMS are required to consult with another provider for people who had any prior cesarean section.
- If a client has had one or two prior C-sections with no prior vaginal birth, the LDM is required to consult specifically with an OB who provides cesarean sections.
- Clients with a history of three C-sections with a previous successful vaginal delivery must have consultation with a physician who provides C-sections.

C. Bailey noted that midwives have benefitted from these consults especially with more complex VBAC cases where clients who've had two prior cesarean sections or one or two previous C-sections with additional risk factors. Consults with another provider, even if it's with another midwife, is an important way to be in touch with any compounding risk factors to help people think more broadly about their clients and to help plan to keep clients safe. Specific plans are made with VBAC clients including plans about care, making sure a client understands that because there's increased risk, there is a need for more frequent vital signs checks, more frequent fetal heart rate checks, if there's a plateau in labor there might be more cervical exams than otherwise done to know if a plateau is occurring, and making more conservative plans for transfer to the hospital if indicated. C. Bailey remarked that midwives are capable of taking risks seriously just like any other risk that midwives interact with.

It was stated that having access to VBACs in free-standing birth centers is a big equity issue for many clients. There are all kinds of reasons why someone choosing a VBAC might not want to deliver in a hospital including:

- Difficulty in finding a truly supportive VBAC provider;
- Fear of being treated poorly with racism or homophobia;
- Fear of being misgendered;
- Fear of fat bias.

C. Bailey stated that they have served many Black, Indigenous, People of Color clients, many queer and transgender clients and they hear about how people don't feel safe in the hospital, need choice in their care and where they want to have their babies.

As an OHP and Medicaid provider, OHP will not pay for a VBAC at home and as such, many clients who are on OHP who choose to have a home birth have to pay out of pocket for their care. This is a huge problem because a lot of people cannot afford it. This means that clients who can afford it can have access to a VBAC with a licensed midwife, while for those who cannot afford the out-of-pocket cost, the only option is to go to the hospital.

Based on their experience with clients who are planning a VBAC, they are a lot more in touch with safety and with risk than any other client. They understand that there are increased risks with their birth. These individuals know about the risks, know what they are choosing, and to not be able to choose is a big deal.

It was stated that if the advice is that persons are not allowed to attend VBACs in birth centers, people not being able to afford the care is more exaggerated because there's a lot of people who choose a birth center birth over a home birth because of in-network options for insurance to pay for that birth and it may not be an option with a home birth midwife.

C. Bailey remarked on how important it is to have skilled providers who know about VBAC and who have trained in it and expressed a lot of gratitude and appreciation for a birth center apprenticeship experience. Having access to training, having attended several VBAC births as a student midwife is important, as lack of experience or training presents additional risks to clients. Many midwives will train at birth centers because birth centers often see a higher volume of clients, and often have more midwives than smaller, home birth practices. More high-risk births become unsafe with a lack of, or loss of, training and ability for people to be skilled providers.

It was further noted that in the past, consults for clients planning a VBAC would be sought from the Legacy Emanuel, Maternal Fetal Medicine clinic; however, it was recently heard that the Legacy clinic's policy has been revised to not accept VBAC consults anymore because they're too low risk and a waste of time. The point of consults is for those providers to repeat what has already been done in terms of talking to the clients about the risks which they already know. (It was stated that a consult would likely occur if it was two or more C-sections with additional risk factors.) It seems like the general understanding in the community, is that people believe that midwives can handle the VBAC client.

It was stated that midwives are really good at informed choice and informed consent, and it is believed that clients should be able to have choice about where they want to give birth.

Jen Kamel

Jen Kamel shared that she is the founder and CEO of VBAC Facts. For the last 16 years, VBAC Facts has worked to provide accurate information on the medical research, medical ethics and political realities to parents, professionals, policy makers and the court so all parties can make informed decisions on this nuance topic.

J. Kamel stated that she will review the following topics:

- Data on VBAC;
- The current state of VBAC access in Oregon;
- What is important to consumers during this work.

<u>Data</u>

J. Kamel stated that the data on VBAC is complex, and there is a lot to consider.

- Wide range of risks at stake, and the choices available to pregnant patients assessing their options for birth after a cesarean.
- Perinatal mortality and morbidity in the current pregnancy and the next pregnancy, maternal mortality, maternal morbidity, and maternal mental health are all factors that play a role which parents are aware of. Parents weigh the risks and benefits of their options in highly individualized manners, and through a variety of personalized filters, including their clinical profile, mental health experiences, past trauma and intended family size.
- Both VBAC and elective repeat cesarean section carry distinct and different risks and ultimately it is the parents' right to decide which set of risks are acceptable.
- Summation of VBAC research in four sentences:
    - The National Institutes of Health stressed back in 2010, VBAC is a reasonable and safe choice for most women with prior cesarean.
    - There is emerging evidence of serious harms related to multiple cesareans.
    - Most women who labor after a cesarean, will have a VBAC, and they and their infants will be healthy.
    - There is a *minority* of women who will suffer serious adverse outcomes of both planned VBAC and elective repeat cesarean section.
- It was stated that this is why no major medical organization supports the idea that a prior cesarean is a reason for a repeat cesarean.
- 2013 to 2020 - the VBAC rate at Oregon Birth Centers was 91 percent, which is higher than any individual Oregon hospital and a stark contrast to the 19 percent VBAC rate statewide.
- It is access to vaginal birth after one cesarean that mitigates the risks of multiple prior cesareans because once someone has two prior cesareans, the odds of ever having a VBAC diminish dramatically.
- Safety or risks involved with out-of-hospital VBAC cannot be understood without understanding risks associated with diminished availability of VBAC in the hospital setting:
    - Maternal morbidity and mortality are strongly associated with cesarean birth, and the odds of repeat cesarean are dramatically higher in the hospital.
    - Per Dr. Elliott Mane, Medical Director of the California Maternal Quality Care Collaborative, there are a lot of hysterectomies, accreta and significant blood loss due to multiple prior cesareans. The biggest risk of the first cesarean is the repeat cesarean. Research clearly ties cesarean to these specific outcomes.
    - Accreta, when the placenta abnormally attaches to the uterine wall, is associated with significant risk of maternal and fetal complications including death. The current recommendation for accreta management is a cesarean hysterectomy ending the fertility of that individual.
    - It was stated that a labor and delivery nurse stated that it is not uterine rupture killing patients, rather it is accreta, increta, and percreta.
    - Per the National Institutes of Health, the risk of maternal death among those who schedule an elective repeat cesarean section is five times higher than those who labor after a cesarean. It was stated that this is important because that group labors after a cesarean, includes those who have a VBAC, as well as those who have a repeat cesarean during labor, including emergency cesareans.
    - When comparing those who plan VBACs to those who schedule repeat cesareans, the risk of maternal death is five times higher in the elective repeat cesarean group,

but it's not just the risk of maternal mortality that is higher with cesareans, it's maternal morbidity as well.
    - The likelihood of many cesarean-related complications increases with each prior cesarean, including uterine rupture, whereas the rate of uterine rupture drops by 50 percent after the first VBAC.
    - Black women have a higher overall cesarean rate and are more likely to plan a VBAC, but are less likely to have a VBAC. As such, they are at a greater risk to experience the short and long-term cesarean complications up to and including death.
    - When talking about safety, we must remember safety for all our citizens with a special focus on marginalized communities. These communities are entitled to respectful, evidence-based care.

<u>VBAC Access in Oregon</u>

- J. Kamel shared that despite the evidence and national recommendations supporting VBAC, medical ethics stating that people have the right to make this choice and repeat cesareans in particular contributing to excess maternal death and morbidity, people do not have the ability to plan a VBAC and avoid repeat cesareans and unnecessary surgery.
    - VBAC is difficult to access across the country, including Oregon. A 2022 study summarized alarm about the risk of uterine rupture, liability concerns, and increasingly stringent standards for surgical readiness overshadow the benefits of successful VBAC, and the risks of repetitive cesarean.
    - Women seek out-of-hospital midwifery support for VBAC, because they have a higher chance of VBAC with midwives, and the best support for physiological birth is with out-of-hospital midwives.
    - In many settings, hospitals do not offer support for physiological birth and do not even offer support for vaginal birth. Out-of-hospital midwifery care is therefore the only option available and the only supported space for vaginal birth after cesarean.
    - The repeat cesarean rate in Oregon is 81%, despite research and guidelines encouraging VBAC access.
    - 69% percent of Oregon counties reported fewer than 10 VBACs during 2023, even though 72% of those counties had at least one hospital.
    - Many hospitals do not offer VBAC, and even among those that do, the odds of having a VBAC in the hospital are far lower than the odds with an out-of-hospital midwife. Women choose out-of-hospital birth because they want to give birth vaginally without medication and this setting is their best choice.
    - One study referenced that some women with higher risk pregnancies will, even with full understanding of the evidence and current recommendations against, seek a community birth, midwife attended, or unassisted birth when they do not have access to vaginal delivery in the hospital, because they do not see cesareans as risk free.
    - Only 19 percent of person with a prior cesarean have a VBAC in Oregon, because hospital VBAC is difficult, if not impossible for many to access, especially in rural areas. While rural hospitals that require repeat cesareans claim this is for patient safety, a recent study on VBAC in community hospitals reported no increased maternal or severe neonatal risk at Tier 1 facilities in comparison to larger hospitals. The resource limitations cited by hospitals as a justification for refusing VBAC, ultimately reflect a financial analysis related to issues like staffing costs.

    - Integration and communication between all parties is key to generating the best outcome. Rural hospitals with labor and delivery units have emergency protocols. These same protocols are engaged if someone transfers into their care from a community setting, or if they call in a physician for someone laboring at their facility. That same study advised overemphasizing hospital tier and volume about the safe delivery of women with a previous cesarean delivery may be displaced and parallels can be seen between community hospital research and birth center VBAC.
- J. Kamel noted that smaller hospitals can and do offer VBAC safety. The same drills and skills' training that makes all births safer, also benefits those planning VBACs. Another study on VBAC in rural hospitals found that while mothers were more likely to experience an infection, hemorrhage, or operative vaginal delivery at urban centers, there was no difference in severe neonatal outcomes by hospital type. A third study found that 42% of rural community hospitals surveyed attended VBAC, illustrating that hospitals with fewer resources can and do offer VBAC.
- It was noted that hostility towards midwives and those who plan birth center VBACs can delay care and contribute to adverse outcomes during hospital transfers. The way to make VBAC safer in all settings is integration and collaboration.
    - In a recent survey of OB residents, only 59% reported that offering planned VBAC was important to them.
    - High repeat cesarean rates and their associated complication rates is a problem OBs and hospitals alone cannot fix.

<u>What is important to consumers?</u>

- Midwifery care at a birth center is vital to Oregonians and represent an opportunity to avoid a repeat cesarean mandated per hospital policy.
    - Restrictive hospital VBAC policies, the impact of prior psychological trauma that occurred during childbirth, and the routine violation of informed consent in hospital labor and delivery units are a few reasons why people seek out-of-hospital birth with midwives.
    - Midwifery care is a refuge from hospital policies that leave them no choice, but a repeat cesarean.
    - Midwifery care is an opportunity to access trauma informed care and to avoid a repeat of the trauma they experienced the first time.
    - Midwifery care represents the best support available for physiological birth. Midwives are the experts of physiological vaginal birth and thus offer the greatest probability of avoiding a repeat cesarean.
    - The out-of-hospital setting is the space in which midwives are best able to support the individual needs of birthing patients.
    - Those in rural communities seek out VBAC at birth centers rather than labor at their home because they want access to midwifery care and want proximity to a hospital.
- The Health Evidence Review Commission (HERC) states in its out-of-hospital birth recommendations, they are weighing rare, but sometimes severe risks to the infant against less severe, but more common maternal harms based on very low-quality evidence. Thus, HERC describes their own recommendations against out-of-hospital birth for those with a prior cesarean as weak.
- Considering the recommendations by the American College of OB/GYNs and the National Institutes of Health relative to the VBAC evidence and medical ethics, VBAC access is

encouraged, and considering the realities of increasing maternal mortality and morbidity rates associated with multiple repeat cesarean sections the objective should be making VBAC more accessible, not less.

- The data and evidence support including safe VBAC access in the freestanding birth center setting as important to protecting public health. J. Kamel urged the State to include consideration of the full range of short and long-term risks that pregnant people face when they navigate the choice between vaginal birth and planned repeat cesarean section to protect their right to weigh the risks and benefits as they apply in their case, and to make the decisions that are best for them.

DISCUSSION

D. Selover opened discussion for questions and comments based on the information shared by the presenters.

- RAC member asked C. Bailey whether they felt like midwives with their training and model of care are skilled at the ongoing risk assessment that is necessary with attending a VBAC in the community setting. Also, is there a benefit to the typical provider to patient ratio (at a home birth or birth center) where it's often 1:1, or 1:2 at the most, providers per patient actively laboring. Is there a benefit for patient safety and women seeking a VBAC. C. Bailey responded that even if there is something high risk or complications that wouldn't be safe to attend at home or in a birth center, having midwifery care, which is more personalized, slowed down, emphasizes continuity, a smaller care team, and longer appointments, makes the care safer for clients.
- RAC member expressed frustration that meetings in the past have been canceled by the OHA due to the lack of BIPOC representation and there is no BIPOC representative at today's discussion which was understood as a requirement. It was further noted that the other subject matter expert who is also a BIPOC participant was told that they couldn't attend. Staff responded that the last few meetings have been canceled at the request of the Oregon Association of Birthing Centers not the OHA. Furthermore, the subject matter expert who responded late was notified that while the agenda had been set, the OHA would have them share their information as time allowed. Staff further noted that passage of HB 2993 requires state agencies to invite communities to participate. With the assistance of RAC members, a BIPOC representative was identified to serve on the RAC, however, because the Birthing Center RAC had already been meeting prior to passage of HB 2993, the program received direction from the Department of Justice and OHA leadership to convene a separate meeting specifically to obtain feedback from communities with a specific emphasis on communities of color. This will allow multiple communities an opportunity to see the entire set of revised rules and provide feedback. This plan to comply with HB 2993 requirements in an existing RAC has previously been shared with the Birthing Center RAC. **FOLLOW-UP – ORS 183.333 states in part that an agency may appoint an advisory committee or use any other means of obtaining public views that will assist the agency in drafting the rule and the membership of an advisory committee appointed under the subsection must represent the interests of persons and communities likely to be affected by the rule.**
- RAC member asked C. Duncan is she could explain to RAC members what it looks like when people receive informed choice in the birth center setting regarding VBAC; options; pros and cons, whether it is a one-minute conversation or five minutes? C. Duncan

responded that it is an ongoing conversation. When someone comes into care an intake risk assessment appointment is made and persons complete a health history. Persons who indicate prior cesarean are asked questions about circumstances of the surgical birth, what happened, did they labor, was it for breach, etc. and that surgical records need to be obtained. Information is shared about increased risks for uterine rupture and that the client will need to be monitored more closely. A third trimester ultrasound is required. It was noted that a lot of clients do not start at 6-weeks, rather they start midwifery care later in the pregnancy when they have already received a lot of information about risk related to a VBAC. Discussions are frank including data and other factors that may contribute to risk. Clients are talked with about what the assessment might look like, how the baby will be listened to more frequently, and there may be need for additional vaginal exams. Client testimony was shared previously and was noted for reference. Individualized plans of care are created with ongoing education and risk mitigation.

- RAC member inquired whether C. Duncan had experience with a hospital provider giving informed choice/informed consent for persons who have been followed by a birthing center but based on agreement with birthing center and client, that a cesarean is needed. C. Duncan responded that conversations are limited with hospital providers, but explained informed choice and informed consent are two different things, especially in the case of an emergency.
- The following comments by RAC members were entered into the Chat:
    - Black and brown women are the ones more likely to die after pregnancy. We need to be hearing from them.
    - Agreement on the importance of always having full BIPOC representation present.
    - Seconding statement about the importance of BIPOC input and needs to be done in a meaningful way.

Current Regulations and Polling

D. Selover shared current regulations based on the requirements of the HERC, the Board of Direct Entry Midwifery, the Health Care Regulation and Quality Improvement Program and the Commission for the Accreditation of Birth Centers. Polls were created to gauge RAC members' feelings about whether the rule should be aligned based on each of the regulatory body's requirements.

Based on the initial set of proposed rules, the Oregon Health Authority (OHA) had aligned language with the Health Evidence Review Commission to require transfer of a care for any client with a history of previous caesarean section. As such, the first poll is whether the OHA shall retain the proposed rule text that requires a person with previous cesarean history to be transferred to a higher level of care.

- For purposes of polling, only RAC members are allowed to vote so the percentage of participation displayed will not align based on the number of attendees in the meeting.
- In response to question on the Chat, staff noted that there is no significance with the coloring scheme of the Chart – it was only to clarify the different regulatory bodies.
- Public member asked via Chat whether the results of the polling could be read aloud for persons participating on the phone. Staff agreed.

POLL: Retain VBAC as a mandatory transfer criterion. Results:

- 0% - I can say an enthusiastic yes to the recommendation (or action).
- 9% - 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.
- 9% - 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.
- 82% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

The following poll was conducted asking whether the OHA should consider adopting the CABC compliance indicators which allow a trial of labor after cesarean in a birth center if certain criteria are met (client has had only one prior cesarean birth; client has a documented low transverse incision; ultrasound demonstrates placental location is not anterior and low lying; client remains consistent with all other risk factor criteria of the birth center). RAC member noted that one criterion, informed consent, was missing. Staff noted that the OHA will require that informed consent be obtained.

POLL: Align requirements with the CABC indicators for accreditation. Results:

- 18% - I can say an enthusiastic yes to the recommendation (or action).
- 9% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 18% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 27% - 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.
- 27% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

D. Selover asked for comments from the RAC regarding the risks and benefits relating to the CABC indicators. Discussion:

- RAC member stated that the American Association of Birth Centers (AABC) sets the standards for birth centers and the CABC defines the indicators for meeting those standards.
  - Most birth centers in Oregon are AABC members, as well as accredited by the CABC.
  - The current CABC indicators support labor after cesarean in a birthing center with the identified risk criteria, as well as comprehensive informed choice specific to risks associated with labor after cesarean; resources for managing emergencies in the birth center; and resources for managing emergencies at the nearest hospital considering the impact of timeliness of access to those resources.
  - The AABC clinical bulletin on VBAC, and position statement on VBAC, and the sample VBAC consent documents were published in 2019.
  - The CABC has supported labor after cesarean in birth center settings since 2014, and the indicators were last updated in 2023 and continue to be supportive within the risk criteria state above.

  - Evidence supports that labor after cesarean is consistent within the definition of low risk when provided within the established risk criteria from other local and national professional organizations, regardless of delivery setting.
  - When support for labor after cesarean is removed from the communities, families will continue to opt for labor after cesarean, but without the guidance of trained and licensed providers in attendance, and further from emergency care. This dramatically increases risk and potential of harm to the residents of Oregon.
  - Duty to protect Oregonians extends to continuing to protect their right to choose labor over repeat cesarean with licensed providers in all settings.
  - Echoing what other subject matter experts have already stated. There are guidelines that help make labor after cesarean in any setting safe. The CABC has used evidence to support their recommendations and that evidence is regularly reviewed and updated.
- RAC member noted that there are eight accredited birth centers in Oregon. There are a total of 12 licensed birth centers in Oregon.
- RAC member expressed via Chat concern with the CABC indicators as it does not allow a trial of labor for a person with two previous cesareans and a prior vaginal birth. Depending on timing and other factors, this is not significantly higher risk, and they should have access to delivery at a birth center. No evidence was presented today that would necessitate removing this requirement which is currently allowed under Oregon birth center rules. RAC members via Chat concurred.
- RAC member further stated that this could present a safety issue as birthing people seeking a VBAC after two cesareans would have to birth at home or have unattended birth as their only option. This will have a greater effect on people in rural areas and potentially BIPOC women as well. RAC member remarked that the CABC indicator may be why other birth centers in rural Oregon are not seeking accreditation. RAC members concurred via Chat.
- RAC member further stated that there is inadequate access to VBAC care in rural communities, but there are small birth centers where people can travel from their home, 2-3 hours from a hospital, and have a VBAC in a birth center with a skilled provider often less than five minutes from a hospital. Making the rule more restrictive will decrease safety.
- RAC member stated that in Josephine County half of the VBACs were in a birth center. Most women in Oregon don't plan to have a VBAC in a birth center. There are only 35 to 40 women a year seeking a VBAC; but for those women, they will be the most affected. It was noted that autonomy is very important.
- RAC member stated that any further restrictions, specifically for Josephine County, would result in additional barriers as there are no providers that will attend a VBAC. It was stated that people will drive four hours, coming from other states, to have the option for a VBAC. A birth center is not going to be the perfect location for every single birthing person, but every pregnant person should have a choice as to where she's going to birth which would be further restricted by aligning with the CABC indicators.
- RAC member indicated they would submit their comments after the RAC meeting. Those comments are attached as Attachment 1.
- RAC member stated via Chat that "out of 37 total counties in Oregon, 26 do not have even one VBAC provider."
- RAC member indicated via Chat "it would not be in support of ACOG guidelines to support patient autonomy."

- RAC member remarked about the general discussion and commented about changing regulations relevant to scope. Those comments are attached as Attachment 2. RAC members concurred with this statement via Chat.

The following polls were conducted with respect to the current Oregon Birth Center administrative rules for a client with a previous uterine wall surgery, including cesarean if certain risk factors are present:

<u>POLL: Retain "conception occurred less than 12 months following surgery or uterine procedure" as mandatory transfer criterion. Results:</u>

- 9% - I can say an enthusiastic yes to the recommendation (or action).
- 45% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 9% - 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.
- 18% - 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.
- 18% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

<u>POLL: Retain "absence of ultrasound to rule out placenta previa or placental attachment to surgical site" as mandatory transfer criterion. Results:</u>

- 36% - I can say an enthusiastic yes to the recommendation (or action).
- 27% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 18% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 18% - 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.

- RAC member stated via Chat that for people who are very uncomfortable with having an ultrasound to determine placenta location, placentas can sometimes be heard with a fetoscope.

<u>POLL: Retain "history of two or more c-sections without a prior successful vaginal delivery" as a mandatory transfer criterion. Results:</u>

- 9% - I can say an enthusiastic yes to the recommendation (or action).
- 27% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 27% - 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.
- 9% - 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.

- 27% - 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 stated that there is sufficient evidence that this is not a problem that needs to be fixed, and the current criteria are supporting women having access to VBAC. RAC member reiterated that anything that restricts the current regulations in place is going to be problematic, pushing pregnant persons to free birth which is essentially an unattended birth. It would push women further away from skilled providers and make birth more dangerous. Women need to be given more autonomy; they can understand and make their own choices about risks. Reference was made to the Strong Start for Mothers and Newborns study and all the benefits of being in birth center care in terms of less preterm birth rate, having higher breastfeeding rates, and a much higher level of satisfaction of care. Compelling evidence is needed to take choice away from women and that evidence does not exist.

<u>POLL: Retain "history of myomectomy which invaded the endometrium" as a mandatory transfer criterion. Results:</u>
- 0% - I can say an enthusiastic yes to the recommendation (or action).
- 55% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 36% - 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.
- 9% - I do not fully agree with the recommendation and need to register concern. however, I will not block the recommendation. More discussion is necessary for full support.
- 0% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

<u>POLL: Retain "history of c-section which included classical incision" as a mandatory transfer criterion. Results:</u>
- 42% - I can say an enthusiastic yes to the recommendation (or action).
- 50% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.
- 8% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 0% - I do not fully agree with the recommendation and need to register concern. however, I will not block the recommendation. More discussion is necessary for full support.
- 0% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

<u>POLL: Retain "history of c-section and complications including postoperative infection, diabetes or steroid use" as a mandatory transfer criterion. Results:</u>
- 27% - I can say an enthusiastic yes to the recommendation (or action).
- 45% - I find the recommendation acceptable and have no serious objections. Improvements could be made but aren't necessary.

- 18% - I can live with the recommendation, but I'm not overly enthusiastic. I have questions about the strengths and weaknesses and need more discussion or more work done.
- 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.
- 9% - I do not agree with the recommendation and will actively block its movement. More discussion is necessary, or an alternative resolution is needed.

The following polls were conducted with respect to the current Board of Direct Entry Midwifery requirements related to c-section(s) and transfer requirements or consultation requirements.

<u>POLL: Align requirements with the Board of Direct Entry Midwifery rules for transfer and consultation. Results:</u>

- 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.

Further comments via Chat:

- Data gathered by Oregon association of birth centers show that from Jan 2013- Feb 2020, Oregon birth centers cared for 271 people planning VBAC, 247 of whom had a vaginal birth. That means 35-40 people plan a VBAC in an Oregon birth center each year, with an overall VBAC rate just over 90%.
- Nationwide data from the Strong Start for Mothers and Newborns study showed a more modest rate of VBAC in birth centers, yet still double the rate of a matched cohort planning a hospital VBAC. (24.2% compared to 12.5%) https://www.birthcenters.org/news/strong-start-national-report.
- 52% of people who die subsequent to pregnancy are due to mental health. The way women give birth matters profoundly.
- Strong Start for Mothers and Newborns data - all those benefits of having care in a birth center (lower rates of preterm and low birth weight infants, higher rates of weekend deliveries, higher rates of breastfeeding) - these findings all apply to clients seeking VBAC as well. This study also showed a reduction in racial/ethnic disparities via the birth center model of care. Another finding in that study is higher rates of extreme satisfaction with their overall care. We sometimes forget to talk about maternal mental health, despite that being the leading cause of perinatal mortality for women in the United States. This study also showed a reduction in racial/ethnic disparities via the birth center model of care as well.
- There is not adequate evidence that all women with two previous cesareans and a vaginal birth should not have the choice to deliver in birth centers. Risk assessment needs to be individualized, and not all VBAC after two c-sections are the same risk profile.

- As a woman forced into a 3rd C-section because of hospital policy, the PTSD and trauma is long-lasting. As a midwife and licensed Perinatal Mental Health Professional seeing women referred to me from our local OB providers after their 6-week checkup for concerns, I see these women for a very long time after their traumatic births. These traumas inflicted upon women leave them feeling helpless, alone, abused, and then with a loss of confidence in not only the medical field but also themselves as mothers. As safe, skilled midwifery providers we fill these huge gaps that Oregon is missing entirely.
- There is an overwhelming amount of data that everyone that meets the current birth center risk criteria should be offered VBAC. For people that choose to have their VBAC in the community setting, birth centers have a demonstrated record of safety and a significant benefit in avoiding repeat cesarean. This is based on the current risk criteria which includes VBA2C with a previous vaginal birth.
- There is a Study on gap between price of vaginal birth vs. price of c/s. Looks like Alaska has passed Oregon in having the widest gap in the price, but Oregon's is still a gap of almost $10K on average. https://healthcostinstitute.org/hcci-originals-dropdown/all-hcci-reports/the-price-of-childbirth-in-the-u-s-tops-13-000-in-2020#:~:text=We%20examined%20the%20price%20of,%2411%2C453%20for%20a%20vaginal%20delivery.
- There is no evidence that VBAC birth is less safe in a birth center than it is in a home birth.
- Birth centers have the potential to be safer due to proximity to the hospital, requirement of transfer protocol for licensure and comprehensive chart and peer review ensure ongoing risk assessment.

RAC member inquired via Chat about financial implications. Staff noted that RAC member will be given an opportunity to review a Statement of Need and Fiscal Impact (SNFI) which includes an equity impact statement. Staff plan to seek input on the potential equity impact during the community meeting and the final draft of the SNFI will be shared with the RAC afterwards.

RAC member shared information on the collection of information related to the benefits of using birth centers including the safety and cost effectiveness. It was noted that there is a disparity between the cost of vaginal birth and the cost of caesarean. When hospitals get more money for a caesarean, they are way more likely to do one. Hospitals prioritize surgical birth and Oregon has the biggest disparity in the nation. RAC member further stated that per a discussion with "Medicaid Oregon," one-third of critical access hospitals in the western United States are expected to close in the next three years so VBAC access in hospital settings will be further reduced. Free birth has been mentioned frequently in part because the Oregon Health Plan does not pay for VBAC. This is something that must be addressed.

RAC member stated that the US is incredibly high with respect to people dying in the process of pregnancy or childbirth. Thirty-two out of 100,000 women are dying after pregnancy and a contributing factor is mental health. People are affected emotionally when they have a birth that feels out of their control when they're not regarded in their birth.

Wrap-Up
D. Selover thanked RAC members for their participation. RAC members were encouraged to submit additional comments to M. Bernal via email. • Goal is to get a complete set of draft rules out to the RAC and get feedback. • Staff will consider all comments received over all the RAC meetings. • The Department of Justice will be considering proposed rules for legal sufficiency based on statutory requirements. • A community meeting will be convened to obtain feedback from communities of color on the proposed rules. It was noted that staff will be working with the Office of the State Public Health Director's, Community Engagement Liaison in identifying communities of color and other communities to invite to the community meeting. RAC members were encouraged to submit their suggestions on community organizations to invite to the community meeting. In response to question posed in the Chat, the community meeting will be a separate meeting from the public hearing. • The RAC will be given an opportunity to review and provide feedback on the Statement of Need and Fiscal Impact (SNFI). • A notice of proposed rulemaking hearing will be filed with the Secretary of State's office along with the final draft rules and the SNFI. Interested parties via the listserv and RAC members will be notified via the birthing center listserv about the public hearing date and written public comment deadline.

RAC adjourned at: 11:58 a.m.

ATTACHMENT 1
Follow-up Comments from RAC Member to 06/04/2024 RAC Meeting

Mellony Bernal

From: K. And <andekaylosu@gmail.com>
Sent: Tuesday, June 4, 2024 12:01 PM
To: Mellony Bernal
Subject: Re: 6/3/2024 meeting FTR Comment

My apologies for the mistype, 6/4/2024 RAC meeting, not 6/3.

On Tue, Jun 4, 2024 at 11:57 AM K. And <andekaylosu@gmail.com> wrote:

Please add this to the record for this meeting.

My points were going to be that limiting access to VBAC in Oregon could have wide-ranging implications for consumers, including impacts on autonomy, maternal health outcomes, psychological well-being, financial considerations, and disparities in access to care. It's essential for policymakers, healthcare providers, and stakeholders to consider these implications when making decisions about maternity care policies and practices.

From a consumer perspective, ensuring access to VBAC involves advocating for policies and practices that support informed decision-making, patient-centered care, and equitable access to maternity services. This may include efforts to address barriers to VBAC, such as limited provider expertise, institutional policies, and reimbursement issues, and to promote shared decision-making between pregnant individuals and their healthcare providers.

ACOG's stance on VBAC emphasizes the importance of individualized care and shared decision-making, with the goal of promoting the best possible outcomes for both mothers and babies while respecting patient preferences and autonomy.

These conversations are not happening through Oregon and we as a committee have failed these women by not prioritizing this conversation in the committee. I have gone through a whole pregnancy and birth since starting this RAC. My baby turned 4 in April this year.

Nearly half of Oregon’s births were paid for by Medicaid for the last 5 years. It’s been a steady 3% of those births happened out of hospital and a steady 2.5 % in hospital. Again, for the last five years. There are women that want this option and deserve to have VBAC in AND out of the hospital offered.

These women deserve true informed choice and respect for their autonomy. I This isn't a matter of yes So what is the compromise and safeguards that we can put in place to ensure the mothers of Oregon have informed choice for VBAC in and out of hospital? We can all agree it’s happening and has been so what’s the next step to support them? The mothers of Oregon look forward to increase of access in hospital if Vbac was removed/restricted as an option for out of hospital birth.

Thank you,

Kaylyn

ATTACHMENT 2
RAC Member Comments on 06/04/2024

"On behalf of Oregon Association of Birth Centers and as an attorney speaking in a meeting about changing regulations relevant to scope, I think we need to bear in mind that the proposal we're discussing here is only relevant to circumstances in which pregnant people make an informed choice to give birth vaginally at a birth center, and the proposal we're discussing is whether the state should order midwives to refuse to support women in that choice and to use the power of law to take that choice off the table."

"In the case of CABC, it's a choice to give birth vaginally after two cesareans. We've heard a lot of information about the full spectrum, the full constellation of risks at stake in that choice, and we are very clear the data is extreme. The data on out-of-hospital VBAC may be weak, but the data on the risks of cesarean is very strong. There is no question that repeat cesarean increases the risk of maternal death, and there is no question that our rising maternal mortality crisis in the United States is a product of, in large part, birthing people's inability to make a free choice about whether to give birth surgically or whether to give birth vaginally. What we're again discussing here is the role that the law plays in that choice. The law without regulations that restrict choice gives pregnant people the right to weigh risks and make decisions."

"Under ORS 677.097, an Oregon statute, doctors have an obligation to inform all patients, everybody seeking health care, about the viable alternatives for treatment and to support the patient in weighing the risks and benefits of their options and making that decision. Vaginal birth is certainly a viable alternative to surgical delivery after one cesarean, after two cesarean, after numbers of cesareans. What just happens is the risk analysis changes; but it is a viable alternative. If ORS 677.097 were being followed, it would mean that after each cesarean, the increased known risks based on data of that increased cesarean for vaginal birth - that information would be provided to the pregnant patient, and the pregnant patient would be able to weigh that information in balance with things like risks to their downstream pregnancies. Only they know how many babies they want to have, their postpartum support situation, and very importantly, their mental health, which we now recognize as a salient health, measurable aspect of health and of public health and one that should be relevant to this discussion."

"Given the statute, every childbirth provider has a statutory obligation to inform pregnant patients about the options of both VBAC and repeat cesarean, and support the pregnant person to weigh the risks and make their own best decision. Yet, as we've heard today, that is not what's happening for reasons that are cultural rather than legal. But the state is supposed to be the enforcer and protector of its own laws, and so my comment here is the question of, is the state protecting the rights of pregnant people? The risk analysis we're discussing here gets to, when is the state justified in ordering providers to take the option of non-surgical birth off the table, as they would do to birth center midwives through the proposed rule change. Throughout the RAC meetings that have reviewed the proposed rule changes that would essentially replace the current birth center tables on scope of services with OHA's HERC guidelines for coverage of out-of-hospital birth, OABC and our members have said if OHA is aware of evidence or events relating to freestanding birth center births in Oregon that justify the proposed restrictions on access to those services, please put that evidence on the table so that we can figure out whether there is a safety gap that would potentially be closed by the proposed changes. At no time has any evidence been presented of any negative outcomes that justify the proposed changes, and so it is for VBAC."

"OABC's data on VBAC in the birth center setting, over all the years that our members have been providing these services, shows that Oregon birth centers have a much, much higher success rate in helping birthing folks give birth vaginally after a cesarean section without negative outcomes that would suggest that those services and those increased improved rates of success are correlated to a safety gap."

"If OHA's focus is on the protection of public health and the safety of birthing people and their babies, they are going to ensure that nobody ever tells a birthing person that the only medical support available to them for childbirth is surgical delivery. And on that front, OHA has a lot of work to do. Hospitals and obstetricians are never ethically or legally justified in taking the viable alternative of vaginal birth off the table for pregnant patients on the basis of prior cesarean. Any effort to increase public health outcomes around childbirth after cesarean section should focus on protecting pregnant patients' rights to supported vaginal birth in the hospital setting. Evidence does not support taking VBAC off the table. OHA's HERC guidance on payment for repeat cesarean reflects its understanding that VBAC should be supported, and I quote from OHA, 'the majority of planned cesareans in the United States are performed for women who have a prior history of cesarean birth.' That's what we're talking about here. A 2010 AHRQ systematic review reports stronger evidence that VBAC is a reasonable and safe choice for the majority of women with prior cesarean and that there is emerging evidence of serious harms related to multiple cesareans. That evidence, that study is 14 years old. OHA goes on, 'planned cesareans without an evidence-based indication may increase neonatal and maternal harms, increase costs and result in unnecessary procedures.' We now know that they do, for sure, increase neonatal and maternal harms, as well as those neonates downstream in future pregnancies, and yet, there are hospitals in this state that tell patients that their only option is repeat cesarean section on the explicit basis that supporting physiological childbirth or even vaginal birth at that hospital after cesarean would make them feel that they should pay an obstetrician or an anesthesiologist to be available for the possible need for an unscheduled surgery."

"Why are those cesareans covered by OHA, particularly in settings that openly refuse support for vaginal birth to women for no other reason than a prior cesarean, when doing so conflicts with OHA's coverage guidance for planned repeat cesarean? The basis for the hospital policy refusing support of VBAC is therefore transparently financial and also happens to profit many hospitals because of the increased provider and facility fees associated with surgical delivery. Yet, the government agencies creating the policies that are supposed to protect the rights of birthing people sometimes state sympathetically that you can't make a doctor or a hospital support a non-surgical birth if they're not comfortable doing so without concern for whether it is ethically or legally permissible to subject a pregnant patient to a surgery that they aren't comfortable receiving as their only option for supported childbirth, even though the evidence is crystal clear that that surgery increases the pregnant patient's risk of mortality and morbidity. In other words, the risks of death."

"In conclusion, nobody works harder than out-of-hospital midwives to protect the physical health, mental health and human rights of birthing people and their babies. When the state uses the power of law to cut off access to out-of-hospital midwifery, it's doing nothing more than enforcing a medical monopoly over obstetric services. This is true now, and it was true 100 years ago when midwives were being pushed out of maternal health care in the USA. In the case of vaginal birth after cesarean it means that forbidding midwives to support VBAC amounts to leveraging the power of law to push pregnant people into surgeries that they neither want nor need. The data is clear that doing so is causally linked to the maternal mortality crisis in the USA. The data is also crystal clear that access to out-of-hospital midwifery care is critical to eliminating the racial mortality disparities that increase the risk of death for black women in the hospital setting. OABC sincerely hopes that OHA will honestly pursue the lodestar of safety and public health by protecting the ability of pregnant Oregonians to access VBAC in the birth center setting."