

Boston Medical Center

c/o Dr. Katharine O’Connell White, Chief of Obstetrics and Gynecology

One Boston Medical Center Place

Boston, MA

02118

October 28, 2024

William Anderson

Office of the General Counsel, Department of Public Health

250 Washington Street

Boston, MA 02108

***RE: Proposed Changes to 105 CMR 130.000: Hospital Licensure***

Mr. Anderson,

On behalf of Boston Medical Center (BMC), we are grateful for the opportunity to provide comments on the proposed changes to *105 CMR 130.000: Hospital Licensure* as they pertain to updates relative to birth center operations. BMC is proud to support a full service tertiary care center for labor and delivery. BMC delivers about 3000 babies a year and 75% of those families are Black and/or Hispanic. In turn, BMC is the birthplace of 1 in 7 Black births and 1 in 13 Hispanic births in Massachusetts.

BMC continuously works to improve and expand care options for all birthing patients and their families. Our OBGYN team is in the process of developing an in-hospital birth center. Our goal is to provide access to a birth center model of care for the primarily low-income families served by BMC’s maternity care practice. As the first alongside midwifery center in Massachusetts, we plan to offer a care model tailored to the preferences and needs of the communities served by the hospital. Capital funding was secured this year, and we hope to open in the Fall of 2025.

We are grateful the department is updating regulations to better accommodate for this care model. Below please find our comments, questions and recommendations related to the proposed changes to *105 CMR 130.000: Hospital Licensure*:

130.020: Definitions

The definition of “Birth Center Services” requires these services to be provided in a freestanding facility. BMC believes the intent of the updated regulations is to allow for these services to occur at in-hospital birth centers or alongside midwifery units. This requirement would restrict these care models from emerging. BMC proposes DPH clarify “birth center services” do not have to occur in a freestanding facility.

BMC suggests adding a new definition of “*Licensed maternity care providers”* as follows:

“*A Licensed Provider whose professional scope of practice includes preconception, prenatal, labor, birth, and postpartum care and early care of the newborn. For the purposes of these regulations, licensed maternity care providers may include but are not limited to: Certified Nurse-Midwives, Certified Professional Midwives, Physicians or others whose professional scope of practice includes preconception, prenatal, labor, birth, and postpartum care and early care of the newborn and who may be the primary attendant during the perinatal period.*”

This definition is consistent with recommendations from the American Association of Birth Centers and promotes the ability to adequately staff birth centers with qualified providers.

130.810: Birth Center Services

BMC suggests the department consider deeming accreditation by the Commission for the Accreditation of Birth Centers (CABC) as an Alongside Midwifery Center or Freestanding Birth Center as evidence of meeting regulation requirements. The CABC has forty years of expertise in setting birth center standards nationally. CABC accreditation ensures that hospital-based birth centers follow the most up-to-date, evidence-based care standards. Deeming accreditation as evidence of meeting regulation requirements would decrease the administrative burden of preparing for both regulatory and accreditation processes and increase the incentive for accreditation.

In 130.810(E), BMC suggests the department update the language for emergency procedures to make it consistent with current resuscitation procedures and terminologies by changing the language to “*Emergency procedures, including adult cardiopulmonary resuscitation and neonatal airway management*.”

130.811: Staffing

Access to birth center care is partially determined by the supply of qualified birth attendants and assistants. BMC believes expanded staffing options should be considered to decrease barriers to birth center care as well acknowledge the future workforce. The expansion of available staff could also help promote the sustainability of birth centers.

BMC proposes changing language in 130.811 to better align with administrative and clinical duties of birth center staff. BMC suggests 130.811(A) be updated to:

*(A) Administrative Director of the Birth Center.*

*(1)  A birth center shall have a director who shall be responsible for the operation and maintenance of the center.*

BMC’s in-hospital birth center model contemplates an administrative director, tasked with operational duties. This position would not require clinical training. This role is consistent with other hospital-owned ambulatory setting administrators. Additionally, the proposed language is also consistent with new statutory language governing the regulations of out of hospital birth centers. Section 51M of Chapter 111 creates “an administrative director responsible for implementing and overseeing the operational policies of the birth center;”. This is a substantively similar role for hospital-owned birth centers.

BMC suggests 130.811(B) be updated to:

*(B) Director of Clinical Affairs.*

*(1) A birth center shall have a Director of Clinical Affairs who shall be a midwife licensed to practice in the Commonwealth. Their professional scope of practice must include preconception, prenatal, labor, birth and postpartum care and early care of the newborn and who may be the primary attendants during the perinatal period.*

*(2) The Director of Clinical Affairs shall be responsible for advising and consulting with the clinical staff of the birth center on all matters related to clinical management of pregnancy, birth, postpartum, newborn and gynecologic health care.*

*(3) Dual Appointment. One person may serve as both Administrative Director and Director of Clinical Affairs if the individual meets the requirements for both positions and can properly perform the duties of both positions.*

The title change from Director of Medical Affairs to Director of Clinical Affairs is consistent with having a midwife in this role, as well as the American Association of Birth Centers standards. It also brings the regulations into alignment with the new state law that clarifies that birth centers may be sites of an autonomous midwifery model of care. These changes would also allow for flexible and efficient use of resources.

BMC proposes adding language to 130.811(C)(1) to include “licensed maternity care providers” the new definition suggested earlier. This would allow for certified-nurse midwives, physicians, soon to be licensed certified professional midwives and other licensed maternity care providers to deliver care in this setting in the future.

In 130.811(C)(3), BMC proposes changing language from “labor and delivery experience” to “*nursing experience with laboring and birthing patients*”. This would allow a nurse with freestanding birth center or home birth experience to staff a birth. These nurses would still need to demonstrate the training or experience detailed in (a) – (d). However, it would expand the labor pool beyond just traditional labor and delivery nurses.

130.813: Patient Records

BMC recommends updating the language in 130.813(B)(4) to “*Complete description of progress of labor and delivery, signed by the licensed maternity care provider*”. Similarly, BMC recommends updating the language in 130.813(B)(6) to “*Description of postpartum course, including complications and treatments, signed by the attending licensed maternity care provider*”. This removes limits on the qualified staff available to attend births in a birth center and updates these sections with the new proposed definition mentioned earlier.

Additionally, BMC recommends updating the language in 130.813(B)(8) to “*Assessments, diagnoses and provision of education*” since this may be performed by the birth attendant in a birth center, rather than a nurse.

130.814: Care and Services

BMC proposes updating language in 130.814(A)(4) to “*breast or chest feeding*” for inclusive language, as well as 130.814(A)(11) to “*perinatal mood disorder screening*” for updated and inclusive clinical language.

In 130.814(D), BMC recommends the language be updated to “*Examinations of birthing persons and newborns shall be performed by the birth center professional staff or a physician, certified nurse-midwife, or other provider trained and licensed to provide postpartum and/or newborn care of the family's choice within 72 hours of birth*.” This would reflect the new definition suggested earlier.

BMC proposes updating the requirement in 130.814(G)(3) to “call the parent or guardian to verify the infant has received the hearing screening *and* document the conversation” from an “and” to an “or”. This is an additional burden that increases the labor cost of follow-up and is unnecessary if the hearing screening has been documented in the electronic health record (the most common scenario in a hospital-based birth center). BMC recommends 130.814(G)(3) be changed to “*Within 2 weeks, confirm hearing screening has been completed and, if not, contact the patient’s parent or guardian*.”

130.815: Prohibited Practices

BMC suggests replacing “forceps” with the term “operative vaginal birth” in 130.815(B)(1). This will prohibit all methods of assisted vaginal delivery. This is consistent with the Commission for the Accreditation of Birth Centers language.

BMC also recommends removing “abortion” from the list of prohibited practices. In alignment with state law and patient needs, midwives working in birth centers can provide safe, compassionate, and effective abortion care. Nationally, birth centers have provided and continue to provide access to safe abortion care.

BMC also suggests revising the restrictions in 130.815(B)(4). The provision of medications within the scope of practice of a birth center provider should not be restricted, as it unnecessarily limits access to reproductive health care. This includes routine medications for common discomforts of pregnancy, contraceptives, and medication abortion. This may be particularly true for low-income people who benefit from programs that offer medications dispensed from a health care setting, such as family planning methods.

Thank you for the opportunity to offer comments regarding these proposed regulations. Should you have any questions about our input, would like further detail or have any feedback for us, please do not hesitate to reach out to Andrea Pessolano, Senior Manager of State Advocacy at [andrea.pessolano@bmc.org](mailto:andrea.pessolano@bmc.org).

Sincerely,

