William Anderson

Office of the General Counsel, Department of Public Health, 250 Washington Street

Boston, MA 02108

Date: October 28, 2024

RE: Healthcare Facility Regulations

Dear Mr Anderson,

I agree with all of the comments made during the Public Comment period. In addition, I want to provide overall feedback and suggestions for the Birth Center Amended Regulations as follows:

1. 105 CMR 130 and 140 need to have the same language in their definitions
	1. Definitions should be updated to follow standards as set by the National Accrediting body for birth centers (AABC)
	2. Should not use” low risk” but rather use language that excludes high-risk which allows for individualization in assessing factors that can co-exist and “low risk” can pose unnecessary restrictions ie.
		1. Birth Center Services. Professional midwifery services provided to **~~low risk childbearing women~~ pregnant persons that are not high- risk** during pregnancy, birth, and **~~puerperium~~ post-partum** and to the infant during the immediate newborn period by nurse-midwives or by obstetricians or family practitioners. (use throughout)
	3. Should define “freestanding” operated by hospitals vs “freestanding” operated by private entity or non-profit
		1. The term “freestanding” simply describes a birth center that exists in a building that is not physically located in a hospital
	4. Should include definition for Alongside Midwifery Unit (AMU) which is a separately located unit not contiguous to labor and delivery that is midwife run (Both Baystate and Boston Medical Center are working towards opening such units)
	5. Should include definition of Certified Professional Midwife
	6. In alignment by statute, there should be a regulation that stipulates who may use “birth center” or “birthing center” in their title. Mt Auburn, Emerson Hospital, Anna Jacques and MetroWest are just a few examples that call their labor and delivery units “birth centers” on their web sites and refer to their units in this way on signage
2. General regulations are confusing as they should be organized by regulations that apply to everyone and then separate regulations that apply to each specific services such as:
	1. Mental Health
	2. Surgical
	3. Dental
	4. Birth Centers
3. Sections under 130 and 140 should be worded the same
	1. 140.911 and 130.810 are the same but have different headings
	2. 140.902 and 130.811 heading should be the same Administrative Director of the Birth Center and regulation the same. Making the distinction between as to who the Administrative Director reports to can be made between Hospital owned and private/non profit owned.
	3. Agree Director of Medical Affairs should be Director of Clinical Affairs
	4. 140.93 and 130.812 E should be changed to
		1. Maternal and neonatal oxygen supplies including portable oxygen available for emergency use.
	5. 140.904 and 130.813 should include documentation of (this needs to be added)
		1. Informed consent and
		2. Informed right to decline
	6. 140.904 and 130.813
		1. Add documentation of Vitamin K
		2. If mother GBS positive date time and verification of antibiotic prophylaxis or if not treated
		3. Report to pediatrician of birth data

Please insert Certified Professional Midwife where Certified Nurse Midwife is mentioned

Please do not put attending physician first as likely will not be the one delivering at the birth center

Please make mention to data collection and that midwife births in the hospital and in birth centers will be in the State Birth Report

1. To include
	1. Vaginal births
	2. VBAC
	3. Cesarean rate, (NTSVD)
	4. Breastfeeding rate at discharge

There is no mention of intrapartum intermittent auscultation and there should be, midwives follow ACNM and AWOHNN standards for auscultation and documentation \*\*\*\*\*this is very important

Thank you for your attention to this matter

Please feel free to contact me with any questions, I have birth center experience and 40 years of experience as a nurse midwife.

Sincerely

Michele

Michele A Helgeson DNP. MPH, CNM, FACNM