



WHO: Health Licensing Office
Board of Direct Entry Midwifery

WHEN: September 8, 2016 at 9 a.m.

WHERE: Health Licensing Office
Rhoades Conference Room
700 Summer St. NE, Suite 320
Salem, Oregon

What is the purpose of the meeting?

The purpose of the meeting is to conduct board business. A working lunch may be served for board members and designated staff in attendance. A copy of the agenda is printed with this notice. Please visit <http://www.oregon.gov/oha/hlo/Pages/Board-Direct-Entry-Midwifery-Meetings.aspx> for current meeting information.

May the public attend the meeting?

Members of the public and interested parties are invited to attend all board/council meetings. All audience members are asked to sign in on the attendance roster before the meeting. Public and interested parties' feedback will be heard during that part of the meeting.

May the public attend a teleconference meeting?

Members of the public and interested parties may attend a teleconference board meeting **in person** at the Health Licensing Office at 700 Summer St. NE, Suite 320, Salem, OR. All audience members are asked to sign in on the attendance roster before the meeting. Public and interested parties' feedback will be heard during that part of the meeting.

What if the board/council enters into executive session?

Prior to entering into executive session the board/council chairperson will announce the nature of and the authority for holding executive session, at which time all audience members are asked to leave the room with the exception of news media and designated staff. Executive session would be held according to ORS 192.660.

No final actions or final decisions will be made in executive session. The board/council will return to open session before taking any final action or making any final decisions.

Who do I contact if I have questions or need special accommodations?

The meeting location is accessible to persons with disabilities. A request for accommodations for persons with disabilities should be made at least 48 hours before the meeting. For questions or requests contact a board specialist at (503) 373-2049.

Approval of Agenda



Health Licensing Office
Board of Direct Entry Midwifery



September 8, 2016 at 9 a.m.
700 Summer St. NE, Suite 320
Salem, Oregon

1. **Call to Order**
2. **Items for Board Action**
 - ◆ Approval of agenda
 - ◆ Approval of minutes – May 12, 2016 and June 9, 2016
3. **Administrative Rule Review**
4. **Communication Report:**
 - Updated on GBS class
 - Update on newsletter
5. **Public/ Interest Parties Feedback**
6. **Executive Session-** Pursuant to ORS 192.660(2)(f) for the purpose of considering information or Records exempt from public inspection. (Legal advice)
7. **Items for Board Action**

Working Lunch

8. **Executive Session-** Pursuant to ORS 192.660(2)(f) for the purpose of considering information or records exempt from public inspection including confidential information pursuant to ORS 687.490. Confidential information, investigative files/ summaries and complaint file numbers
9. **Items for Board Action**
10. **Other Board Business**

Agenda is subject to change.
For the most up to date information visit www.oregon.gov/oha/hlo

Approval of Minutes

May 12, 2016



Health Licensing Office
Board of Direct Entry Midwifery



May 12, 2016
700 Summer Street NE, Suite 320
Salem, Oregon

MINUTES

MEMBERS PRESENT

Colleen Forbes, chair
James di Properzio, vice-chair
Wendy Smith
Kelli McIntosh
Sarah Taylor
Niamh Charles

STAFF PRESENT

Sylvie Donaldson, interim director and division manager
Bob Bothwell, regulatory operations manager
Samie Patnode, policy analyst
Heather Vogelsong, assistant attorney general
Sarah Kelber, communications coordinator

MEMBERS ABSENT

Stephanie Elliot

GUESTS PRESENT

Call to Order

Colleen Forbes called the meeting of the Board of Direct Entry Midwifery to order at 9:05 a.m. Roll was called.

Items for Board Action

Approval of Agenda

Wendy Smith made a motion with a second by James di Properzio to approve the agenda. Motion passed unanimously.

Deliberate on Contested Case Number 10-5969 and 11-6546

- The Board of Direct Entry left the public meeting to deliberate on contested cases number 10-5969 and 11-6546 under ORS 192.690(1) at 9:08 a.m. on May 12, 2016.
- The public meeting reconvened at 9:56 a.m. it was noted that no decisions were made and No votes were made.

In regards to case number 10-5969

- It was proposed that the board move to adopt the proposed settlement agreement, and stipulated final order.

MOTION:

Niamh Charles made a motion with a second by James di Properzio. Motion passed unanimously.

In regards to case number 11-6546

It was proposed that the board move to reject the settlement proposal, and offer the licensee a settlement of:

- 1 year suspension
- Engage in Oregon Midwifery Council's peer review, and full chart review for 5 clients with births between 11-14 and 1-7-16 in which 2 of the 5 clients were transferred to the hospital.
- Supervision for the 10 first births following the suspension. After the first 5 births the board will review, and determine if a different supervisor will be needed for the second 5 births.

This is all contingent upon the board chair approval of the final terms, and language of the written agreement, and final order.

MOTION:

James di Properzio made a motion with a second by Wendy Smith. Motion passed unanimously.

Other Board Business

Staff, and members would like the following topics added to the next board meeting.

- Review the "Midwifery Supervision Guidelines" to make changes if needed.
- Rubric review
- Administrative Rule Process

The meeting adjourned at approximately 10:01 a.m.

Minutes prepared by: Maria Gutierrez, board specialist

Approval of Minutes

June 9, 2016



Health Licensing Office
Board of Direct Entry Midwifery



June 9, 2016
700 Summer Street NE, Suite 320
Salem, Oregon

MINUTES

MEMBERS PRESENT

Colleen Forbes, chair
Wendy Smith
Kelli McIntosh
Niamh Charels
Sarah Taylor
Beth Eiva

STAFF PRESENT

Sylvie Donaldson, interim director and division manager
Bob Bothwell, regulatory operations manager
Samie Patnode, policy analyst
Heather Vogelsong, assistant attorney general
Sarah Kelber, communications coordinator
Trampus Schuck, investigator/ inspector
Nathan Goldberg, investigator/ inspector
Maria Gutierrez, board specialist

MEMBERS ABSENT

Stephanie Elliott

GUESTS PRESENT

Call to Order

Colleen Forbes called the meeting of the Board of Direct Entry Midwifery to order at 9:15 a.m. Roll was called.

Board members, and staff introduced themselves for new board member. Beth Eiva, who was recently appointed to the public member's position provided an overview of her professional background.

Items for Board Action

Approval of Agenda:

Wendy Smith made a motion with a second by Sarah Taylor to approve the agenda. Motion passed unanimously.

Approval of Minutes:

Wendy Smith made a motion with a second by Niamh Charles to approve the minutes for February 11, 2016, and March 31, 2016. Motion passed unanimously.

Administrative Rule Review:

Samie Patnode, policy analyst, starts discussion on administrative rule review as the board is scheduled to review and revise rules as needed.

Board members review, and discuss Oregon Administrative Rules Division 15 and Division 20

Members would like the following topics revised, or further looked into:

Listed under application requirements 332-015-0030

It was brought to the member's attention that the need of a high school diploma, or equivalent is not listed under licensing requirements. The discussion will be continue at a later time when the statutes are open to make changes.

Education 332-015-0040

Members discuss the importance of mainintaing a current certification with NARM, and how it's currently not listed that way in rules. The office is going to do further research into the statues to determine what's permitted.

Members would like to get a parking lot of issues started for statues in the event that the statues are open for changes.

Discussion returns to application requirements 332-015-0030

Discussion on the current requirements of continuity of care, and the possibility of increasing the continuity of care.

Members discuss the possibility, and the importance of increasing the level of education for midwives.. Below are a couple of thoughts members have for changes to 332-015-0030 (6)

6) Pursuant to ORS 687.420 an applicant must:

(a) Participation as an assistant at 50 deliveries

(b) Be the primary birth attendant at 50 deliveries The applicant must have provided continuity care for at least 10 of the primary birth attendant deliveries, including four prenatal visits, one newborn examination and three postpartum exam.

50 deliveries for which the applicant was the primary birth attendant, participation in 100 prenatal care visits, 25 newborn examinations, and 40 postnatal examinations. Of these 50 births, at least 25 deliveries must have taken place in an out-of-hospital setting and 10 births must have occurred within the two years or 24 months preceding the date of application.

Under definitions 332-015-000

Add newborn to definition section to state "newborn means is a baby from birth till 28 days."

Add postpartum to definition to say “postpartum is the period of time immediately after, and up to 8 weeks following the birth of baby.

Division 20 will be discussed at the next board meeting scheduled for July 14, 2016.

Public/ Interest Parties Feedback:

None

Executive Session:

- The Board of Direct Entry Midwifery entered executive session pursuant to ORS 619.660(2)(f) at 11:13 a.m. on June 9, 2016 for the purpose of considering information or records related to legal advice exempt from public inspection.
- Executive session concluded and the board reconvened regular session at 11:56 a.m. it was noted that no decision was made and no votes were made in executive session.

Board members discuss a rubric chart, and the possibility of adding a specific division under the Oregon Administrative Rules pertaining to civil penalties to provide guidance on the different type of cases, and possible civil penalty fees.

Sarah Kelber, communications coordinator is going to work on a newsletter of current hot topics going on.

Deliberate on Contested Case Number 11-6546

- The Board of Direct Entry Midwifery left the public meeting to deliberate on contested case number 11-6546 under ORS 192.690(1) at 12:15 p.m. on June 9, 2016.
- The public meeting reconvened at 12:21 p.m. it was noted that no decisions were made and no votes were made.

In regards to case number 11-6546

- It is proposed to approve the signed settlement agreement, and stipulated order, and delegate authority to the board chair to sign the settlement and stipulated final order.

MOTION

Niamh Charles made a motion with a second by Wendy Smith. Motion passed unanimously.

Executive Session

- The Board of Direct Entry Midwifery entered executive session pursuant to ORS 619.660(2)(f) at 12:22 p.m. on June 9, 2016 for the purpose of considering information or records exempt from public inspection including confidential information pursuant to ORS 687.490 confidential information, investigative files/summaries and complaint files.
- Executive session concluded and the board reconvened regular session at 1:19 p.m. it was noted that no decision was made and no votes were made in executive session.

Items for Board Action-Investigative files/ summaries

In regards to case number 16-8081

- It was proposed to close, and end the investigation.

MOTION:

Wendy Smith made a motion with a second by Kelli McIntosh. Motion passed unanimously.

Director Report:

Sylvie Donaldson, interim director and division manager, reported the following:

- The current need for more subject matter experts, and doing an outreach to find more subject matter experts.

Forbes, provides an updated of who, and what OHA/DEMAP is and what they do. The office is going to do an outreach to Kim West to attend one of the board meetings to provide members with further information of what their claim processes look like.

Kelber, provides members with an update on the following:

- Trying to set up G.B classes for midwives who are still needing to take the class.
- Trying to set up an online training with I learn for midwives who are needing to take their L&D class for renewals.

Licensing and Fiscal Statistical Reports:

Donaldson, presented an overview of statistics related to the board. Statistics include licensing statistics, license volumes and active license trends.

The statement of cash flow for the period 07/01/15-06/30/17 was reviewed.

Regulatory Report:

Bob Bothwell, regulatory operations manager, reported on enforcement activity including:

2013-2015 Biennium

Between July 1, 2013 and June 30, 2015, 19 complaints were received. Of the 19 complaints 0 remain open. A summary of allegations received by type of complainant was provided as stated below.

Mandatory Reporter	Client	Other
13	0	6

2015-2017 Biennium

Between July 1, 2015 and April 30, 2016, 54 complaints were received. Of the 54 complaints 11 remain open. A summary of allegations received by type of complainant was provided as stated below.

Mandatory Reporter	Client	Other
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49	2	3
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Other Board Business

The meeting adjourned at approximately 2:03 p.m.

Minutes prepared by: Maria Gutierrez, board specialist

Administrative Rule Review



ADMINISTRATIVE RULE SCHEDULE

HEALTH LICENSING OFFICE BOARD OF DIRECT ENTRY MIDWIFERY

Date	Action	Time
March 31, 2016	Approve rulemaking schedule	9 am
April 14, 2016	Board meeting – 2 hour review definitions, application requirements including education & examination	9 am
May 12, 2016	Board meeting – conference call no rule review	9 am
June 9, 2016	Board meeting – 2 hour review definitions, application requirements including education & examination continued	
July 14, 2016	Board meeting – 2 hours review renewal, reporting and continuing education requirements	9 am
August 17, 2016	Board meeting – meeting cancelled	9 am
October 6, 2016	Board meeting – 2 hours general practice standards	9 am
November 10, 2016	Board meeting – 2 hours absolute risk assessment & transfer care	9 am
December 8, 2016	Board meeting – 2 hours absolute risk antepartum	9 am
January 12, 2017	Board meeting – 2 hours absolute risk intrapartum	9 am
February 16, 2017	Board meeting – 2 hours absolute risk postpartum	9 am
March 23, 2017	Board meeting – 2 hours absolute risk infant	9 am
April 20, 2017	Board meeting – 2 hours non-absolute risk assessment & consultation	9 am
May 18, 2017	Board meeting – 2 hours non-absolute risk antepartum	9 am
June 22, 2017	Board meeting – 2 hours non-absolute risk intrapartum	9 am
July 20, 2017	Board meeting – 2 hours non-absolute risk postpartum	9 am
August 24, 2017	Board meeting – 2 hours non-absolute risk infant	9 am
September 21, 2017	Board meeting – 2 hours mother care during pregnancy	9 am
October 19, 2017	Board meeting – 2 hours mother care during labor including auscultated acceleration testing	9 am
November 30, 2017	Board meeting – 2 hours mother care after delivery	9 am
December 21, 2017	Board meeting – 2 hours newborn care	9 am
January 11, 2018	Board meeting – 2 hours decline procedure & fetal surveillance testing	9 am
February 15, 2018	Board meeting – 2 hours records of care including charting & required written documentation	9 am

March 29, 2018	Board meeting – 2 hours informed consent & traditional midwife patient disclosure	9 am
April 26, 2018	Board meeting – 2 hours terminating midwifery care	9 am
May 30, 2018	Board meeting – 2 hours access, administration and approved legend drugs & devices & determine membership of Rules Advisory Committee	9 am
June 21, 2018	Rules Advisory Committee	9 am
July 12, 2018	Board meeting	9 am
August 30, 2018	Rules Advisory Committee	9 am
October 1, 2018	Board meeting approve proposed rules	
October 22, 2018	Notice of proposed rules in Oregon Bulletin	9 am
October 31, 2018	Public rule hearing	5 pm
November 29, 2018	Last day for public comment	9 am
	Board meeting review public comment, hearing officer report and adopt permanent rules	
January 1, 2019	Effective date of permanent rule	

Comments received prior to October 1, 2018 will not be considered by the Health Licensing Office or the Board of Direct Entry Midwifery.

Please send all public comment or questions to:

Samie Patnode, Policy Analyst

700 Summer St NE, Suite 320, Salem, OR 97301-1287

samie.patnode@state.or.us . Work: (503) 373-1917

All meetings are held at the Health Licensing Office, Rhoades Conference Room, 700 Summer St, Suite 320, Salem, OR 97301, unless otherwise specified. Members of the public are invited and encouraged to attend all board and committee meetings. However, audience members will not be allowed to participate.

Invited technical experts may be invited to participate in meetings regarding their knowledge and expertise in specific areas. For current information regarding administrative rules or the rulemaking process visit the Web at

<http://www.oregon.gov/oha/hlo/Pages/Board-Direct-Entry-Midwifery.aspx>

**OREGON HEALTH AUTHORITY
HEALTH LICENSING OFFICE, BOARD OF DIRECT ENTRY MIDWIFERY**

DIVISION 25

PRACTICE STANDARDS

332-025-0020

General Practice Standards

Pursuant to ORS 687.480, licensees must comply with the following practice standards when, advising the mother and in rendering antepartum, intrapartum and postpartum care.

- (1) A licensee must include the designation LDM after the licensee's name when completing birth certificates; and
- (2) As a condition of license renewal, licensees must participate in peer review meetings in their regions or in conjunction with professional organization meeting(s), which must include, but are not limited to, the discussion of cases and obtaining feedback and suggestions regarding care. Documentation must be made on forms approved by the board. Licensees must participate in peer review according to the following schedule:
 - (a) Once per year if the licensee served as the primary birth attendant at 40 or fewer births during the license year; or
 - (b) Twice per year if the licensee served as the primary birth attendant at more than 40 births during the license year.
 - (c) For the purpose of reporting peer review, if there is more than one birth attendant present at the same birth, the birth attendants must designate which birth attendant is primary.
 - (d) If a licensee has not attended any births, participation in peer review is not required. Licensee must attest to not having attended any births on a form prescribed by the agency.
- (3) In accordance with ORS 687.480 and 687.493 a licensee must maintain equipment necessary to: assess maternal, fetal and newborn well being; maintain aseptic technique; respond to emergencies requiring immediate attention; and to resuscitate mother and newborn when attending an out-of-hospital birth.

(4) A licensee must dispose of pathological waste resulting from the birth process in accordance with the Department of Human Services Public Health Division under OAR 333 division 056. Provisions include:

(a) Incineration, provided the waste is properly containerized at the point of generation and transported without compaction to the site of incineration; or

(b) Burial on private property if burial of human remains on such property is not prohibited or regulated by a local government unit at the designated site.

(5) Licensees must dispose of biological waste materials that come into contact with blood and/or body fluids in a sealable plastic bag (separate from sealable trash or garbage liners) or in a manner that protects the licensee, mother, baby, and others who may come into contact with the material during disposal. Biological wastes may also be incinerated or autoclaved in equipment dedicated to treatment of infectious wastes.

(6) Licensees must dispose of sharps that come into contact with blood or bodily fluids in a sealable, (puncture proof) container that is strong enough to protect the licensee, mother, baby and others from accidental cuts or puncture wounds during the disposal process.

(7) Sharps must be placed into appropriate containers at the point of generation and may be transported without compaction to a landfill having an area designed for sharps burial or transported to an appropriate health care facility equipped to handle sharps disposal, provided the lid of the container is tightly closed or taped to prevent the loss of content and the container is appropriately labeled.

(8) Licensees must maintain a “patient disclosure form” providing current and accurate information to prospective clients. Licensees must provide the mother with this information. This statement must include, but is not limited to:

(a) Philosophy of care;

(b) Midwifery training and education;

(c) Clinical experience;

(d) Services provided to mother and baby;

(e) Types of emergency medications and equipment used if appropriate;

(f) Responsibilities of the mother and her family;

(g) Fees for services including financial arrangements;

(h) Malpractice coverage;

(i) Risk assessment criteria as listed in OAR 332-025-0021;

(j) Whether the licensee has obtained the 40 hours of Initial renewal Legend Drugs and Devices continuing education required under OAR 332-020-0010 or the additional eight hours continuing education in intravenous antibiotics for Group B Streptococcal prophylaxis; and

(k) Signature of mother and date of signature documenting discussion and receipt of patient disclosure form.

(9) A licensee must maintain a plan for emergency transport and must discuss the plan with the mother. The plan must include, but is not limited to:

(a) Place of transport;

(b) Mode of transport;

(c) Provisions for hospital and physician support including location and telephone numbers; and

(d) Availability of private vehicle or ambulance including emergency delivery equipment carried in the vehicle.

(10) Signature of mother and date of signature documenting discussion of emergency transport plan must be placed in the mother's record.

(11) A licensee must maintain complete and accurate written records documenting the course of midwifery care as listed under OAR 332-025-0110.

(12) A licensee must maintain current certification in cardiopulmonary resuscitation for adults and infants and current certification in neonatal resuscitation.

(13) All births must be registered with the Department of Human Services Vital Records Section, as provided in ORS Chapter 432.

Stat. Auth.: ORS 676.605, 676.615, 687.480 & 687.485

Stats. Implemented: ORS 676.605, 676.615, 687.480 & 687.485

Hist.: DEM 1-1993(Temp), f. & cert. ef. 12-22-93; DEM 1-1994, f. & cert. ef. 6-15-94; DEM 2-1998, f. 4-14-98, cert. ef. 4-15-98; DEM 1-1999(Temp), f. 9-1-99, cert. ef. 9-9-99 thru 2-29-00; DEM 2-1999, f. 12-17-99, cert. ef. 12-20-99; DEM 2-2000(Temp), f. 8-22-00, cert. ef. 8-22-00 thru 2-17-00; DEM 2-2000(Temp), f. 8-22-00, cert. ef. 8-22-00 thru 2-17-01; DEM 3-2000, f. 9-29-00, cert. ef. 10-1-00; DEM 1-2001(Temp), f. & cert. ef. 10-1-01 thru 3-29-02; Administrative correction 11-7-01; DEM 1-2002, f. 2-25-02 cert. ef. 3-1-02; DEM 1-2004, f. 6-29-04, cert. ef. 7-1-04; DEM 6-2010, f. 12-30-10, cert. ef. 1-1-11; DEM 1-2011(Temp), f. & cert. ef. 4-4-11 thru 9-27-11; DEM 5-2011, f. & cert. ef. 9-26-

11; DEM 1-2014(Temp), f. 12-31-14, cert. ef. 1-2-15 thru 6-27-15; DEM 2-2015, f. & cert. ef. 7-1-15

332-025-0021

Risk Assessment Practice Standards

Licensees must assess the appropriateness of an out-of-hospital birth taking into account the health and condition of the mother and baby according to the following absolute and non-absolute risk criteria:

(1) "Absolute risk" as used in this rule means conditions or clinical situations of obstetrical or neonatal risk that cannot be resolved and that preclude out-of-hospital care. If the mother or baby presents with any absolute risk factors, the LDM must:

- (a) During the antepartum period, plan for transfer of care and an in-hospital birth;
- (b) During the intrapartum period, arrange transportation to the hospital and transfer of care unless the birth is imminent;
- (c) When the birth is imminent, take the health and condition of the mother and baby and conditions for transport into consideration in determining whether to proceed with out-of-hospital birth or to arrange for transportation to a hospital and transfer of care;
- (d) During the postpartum period, arrange for transportation of mother or baby to a hospital and transfer of care;

(2) The following constitute absolute risk factors:

(a) ANTEPARTUM ABSOLUTE RISK CRITERIA:

- (A) Active cancer;
- (B) Cardiac condition with hemodynamic consequences;
- (C) Severe renal disease — active or chronic;
- (D) Severe liver disease — active or chronic;
- (E) Uncontrolled hyperthyroidism;
- (F) Chronic obstructive pulmonary disease;
- (G) Essential chronic hypertension over 140/90;
- (H) Pre-eclampsia/eclampsia;

- (I) Current venous thromboembolic disease;
 - (J) Current substance abuse known to cause adverse effects for the mother or baby;
 - (K) Incomplete spontaneous abortion;
 - (L) Hemoglobin under nine at term;
 - (M) Placental abruption;
 - (N) Placenta less than 2.0 centimeters from internal os at onset of labor;
 - (O) Persistently or severely abnormal quantity of amniotic fluid;
 - (P) Signs and symptoms of chorioamnionitis;
 - (Q) Ectopic pregnancy;
 - (R) Pregnancy lasting longer than 43 weeks gestation (21 days past the due date);
 - (S) Any pregnancy with abnormal fetal surveillance tests;
 - (T) Active acquired immune deficiency syndrome (AIDS);
 - (U) Higher order multiples (three or more);
 - (V) Monochorionic, monoamniotic twins;
 - (W) Twin-to-twin transfusion;
 - (X) Presenting twin transverse;
 - (Y) Three cesarean sections unless previous successful vaginal birth;
 - (Z) Placenta accreta, percreta or increta;
 - (AA) Non-cephalic presentation except as noted in non-absolute risk criteria;
 - (BB) Previous classical uterine incision, T-incision, prior uterine rupture or extensive transfundal surgery;
 - (CC) Four or more cesarean sections; and
 - (DD) Pre-existing diabetes requiring oral medication or insulin.
- (b) INTRAPARTUM ABSOLUTE RISK CRITERIA:

- (A) Documented intrauterine growth restriction at term;
 - (B) Evident or suspected uterine rupture;
 - (C) Prolapsed cord or cord presentation;
 - (D) Evident or suspected complete or partial placental abruption;
 - (E) Evident or suspected placenta previa;
 - (F) Evident or suspected chorioamnionitis;
 - (G) Pre-eclampsia/eclampsia;
 - (H) Thick meconium-stained amniotic fluid without reassuring fetal heart tones and birth is not imminent;
 - (I) Evidence of fetal distress or abnormal fetal heart rate pattern unresponsive to treatment or inability to auscultate fetal heart tones;
 - (J) Excessive vomiting, dehydration, acidosis or exhaustion unresponsive to treatment;
 - (K) Blood pressure greater than or equal to 150/100 which persists or rises, and birth is not imminent;
 - (L) Labor or premature rupture of membrane less than 35 weeks according to estimated due date;
 - (M) Current substance abuse known to cause adverse effects for the mother or baby;
 - (N) Retained placenta with suspected placenta accreta;
 - (O) Active herpes lesion in an unprotectable area;
 - (P) Primary herpes outbreak in labor; and
 - (Q) Evident or suspected footling or kneeling breech.
- (c) MATERNAL POSTPARTUM ABSOLUTE RISK CRITERIA:
- (A) Retained placenta with suspected placenta accreta;
 - (B) Retained placenta with abnormal or significant bleeding;
 - (C) Laceration requiring referral of care for repair including but not limited to third and fourth-degree lacerations;

- (D) Uncontrolled postpartum bleeding;
- (E) Increasingly painful or enlarging hematoma;
- (F) Development of pre-eclampsia; and
- (G) Signs or symptoms of shock unresponsive to treatment.

(d) INFANT ABSOLUTE RISK CRITERIA:

- (A) Apgar less than 7 at 10 minutes of age;
- (B) Respiration rate greater than 100 within the first two hours postpartum, and greater than 80 thereafter, lasting more than one hour without improvement;
- (C) Persistent nasal flaring, grunting, or retraction after one hour of life without improvement;
- (D) Seizures;
- (E) Apnea;
- (F) Central cyanosis;
- (G) Large or distended abdomen;
- (H) Any condition requiring more than 12 hours of observation postbirth;
- (I) Persistent poor suck, hypotonia or a weak or high-pitched cry;
- (J) Persistent inability to maintain temperature between 97-100 degrees Fahrenheit;
- (K) Persistent projectile vomiting or emesis of fresh blood; and
- (L) Signs and symptoms of infection in the infant.

(3) "Non-absolute" means a condition or clinical situation that places a mother or baby at increased obstetric or neonatal risk, but does not automatically exclude a mother and baby from an out-of-hospital birth.

(4) When a mother or baby presents with one or more non-absolute risk factors, the LDM must:

- (a) Arrange for the transfer of care of the mother or baby; or
- (b) Comply with all of the following:

(A) Consult with at least one Oregon licensed health care provider regarding the non-absolute risk factors present.

(B) Discuss the non-absolute risk(s) with the mother, including:

(i) Possible adverse outcomes;

(ii) Whether an out-of-hospital birth is a reasonably safe option based upon the risk(s) present;

(iii) The anticipated risk(s) and the likelihood of reducing or eliminating said risks;

(iv) The midwife's experience with said risk(s);

(v) The ease and time involved in accomplishing transport or transfer of care;

(vi) Recommendation(s) given by the consulting Oregon licensed health care provider(s); and

(vii) Recommendation(s) given by the LDM to the mother.

(C) Document discussion of information listed in subsection (B).

(D) To the extent the LDM acts contrary to the recommendations given by the consulting Oregon licensed health care provider, the LDM must document the justification.

(E) Informed consent must be obtained and documented in records.

(5) The following are non-absolute risk factors:

(a) MATERNAL ANTEPARTUM NON-ABSOLUTE RISK CRITERIA:

(A) Conditions that could negatively affect maternal or fetal status that require ongoing medical supervision or ongoing use of medications;

(B) Inappropriate fetal size for gestation;

(C) Significant second or third trimester bleeding;

(D) Abnormal fetal cardiac rate or rhythm;

(E) Decreased fetal movement;

(F) Uterine anomaly;

- (G) Anemia (hematocrit less than 30 or hemoglobin less than 10 at term);
 - (H) Seizure disorder requiring prescriptive medication;
 - (I) Platelet count of less than 75,000;
 - (J) Isoimmunization to blood factors;
 - (K) Psychiatric disorders;
 - (L) History of thrombophlebitis and hemoglobinopathies;
 - (M) Dichorionic, diamniotic twins;
 - (N) Monochorionic, diamniotic twins;
 - (O) Known fetal anomalies that require medical attention at birth;
 - (P) Two cesarean sections without previous successful vaginal birth;
 - (Q) Three cesarean sections with a previous successful vaginal birth;
 - (R) Blood coagulation defect;
 - (S) Significant glucose intolerance unresponsive to dietary and exercise intervention;
 - (T) Gestational diabetes well controlled with diet or oral glycemic medications; and
 - (U) Primary herpes outbreak.
- (b) INTRAPARTUM NON-ABSOLUTE RISK CRITERIA:
- (A) No prenatal care or unavailable records;
 - (B) History of substance abuse during this pregnancy;
 - (C) Signs and symptoms of infection including but not limited to a temperature 100.4 degrees Fahrenheit or higher with adequate hydration in the mother;
 - (D) Labor or premature rupture of membrane from 35 to 36 weeks gestation;
 - (E) Frank and complete breech presentation, as determined by vaginal examination;
 - (F) Lack of adequate progress in second stage:

(i) Lack of adequate progress in vertex presentation is when there is no progress after a maximum of three hours in cases with full dilation, ruptured membranes, strong contractions and sufficient maternal effort; and

(ii) Lack of adequate progress in breech presentation is when there is no progress in descent after a maximum of one hour in cases with full dilation, ruptured membranes, strong contractions and sufficient maternal effort.

(c) MATERNAL POSTPARTUM NON-ABSOLUTE RISK CRITERIA:

(A) Signs and symptoms of infection;

(B) Any condition requiring more than 12 hours of postpartum observation;

(C) Retained placenta greater than two hours with no unusual bleeding;

(D) Evidence of urinary retention that cannot be resolved in an out-of- hospital setting;
and

(d) INFANT NON-ABSOLUTE RISK CRITERIA:

(A) Apgar less than 7 at five minutes without improvement;

(B) Weight less than 2,270 grams (five lbs.);

(C) Failure to void within 24 hours or stool within 48 hours from birth;

(D) Excessive pallor, ruddiness, or jaundice at birth;

(E) Any generalized rash at birth;

(F) Birth injury such as facial or brachial palsy, suspected fracture or severe bruising;

(G) Baby with signs and symptoms of hypoglycemia unresolved in the out-of-hospital setting;

(H) Weight decrease in excess of 10 percent of birth weight that does not respond to treatment;

(I) Maternal-infant interaction problems;

(J) Direct Coomb's positive cord blood;

(K) Infant born to HIV positive mother;

(L) Suspected or evident major congenital anomaly;

(M) Estimated gestational age of less than 35 weeks;

(N) Maternal substance abuse identified postpartum; and

(O) Cardiac irregularities, heart rate less than 80 or greater than 160 (at rest) without improvement, or any other abnormal or questionable cardiac findings.

(6) For the purpose of this rule “transfer of care” means the process whereby any LDM who has been providing care relinquishes this responsibility to a hospital or to licensees under ORS chapter 682.

(a) The LDM must provide the following at the time of transfer, to the hospital or licensees under ORS chapter 682: medical history, prenatal flow sheet, diagnostic studies, laboratory findings, and maternal and baby care notes through time of transfer;

(b) In cases of emergency, at the time of transfer, the LDM must provide the records required in subsection (a) to the hospital or licensees under ORS chapter 682, including notes for care provided during the emergency, if available. If notes are not available, an oral summary of care during the emergency must be made available to the hospital or licensees under ORS chapter 682; and

(c) Under no circumstances shall the midwife leave the mother or baby until such a time that transport is arranged and another Oregon licensed health care provider or a licensee under ORS chapter 682 assumes care.

(7) For the purpose of this rule “consultation” means a dialogue for the purpose of obtaining information or advice from an Oregon licensed health care provider who has direct experience handling complications of the risk(s) present, as well as the ability to confirm the non-absolute risk, which may include, but is not limited to confirmation of a diagnosis and recommendation regarding management of medical, obstetric, or fetal problems or conditions. Consultation may be by phone, in person or in writing.

(8) For the purpose of this rule “Oregon licensed health care provider” means a physician or physician assistant licensed under ORS 677, a certified nurse midwife or nurse practitioner licensed under ORS 678, a naturopath licensed under ORS 685, or a licensed direct entry midwife licensed under ORS 687.

Stat. Auth.: ORS 676.605, 676.615, 687.480 & 687.485

Stats. Implemented: ORS 676.605, 676.615, 687.480 & 687.485

Hist.: DEM 1-1993(Temp), f. & cert. ef. 12-22-93; DEM 1-1994, f. & cert. ef. 6-15-94; DEM 2-1998, f. 4-14-98, cert. ef. 4-15-98; DEM 1-1999(Temp), f. 9-1-99, cert. ef. 9-9-99 thru 2-29-00; DEM 2-1999, f. 12-17-99, cert. ef. 12-20-99; DEM 2-2000(Temp), f. 8-22-00, cert. ef. 8-22-00 thru 2-17-00; DEM 2-2000(Temp), f. 8-22-00, cert. ef. 8-22-00 thru 2-17-01; DEM 3-2000, f. 9-29-00, cert. ef. 10-1-00; DEM 1-2001(Temp), f. & cert. ef. 10-1-01 thru 3-29-02; Administrative correction 11-7-01; DEM 1-2002, f. 2-25-02 cert. ef. 3-

1-02; DEM 1-2004, f. 6-29-04, cert. ef. 7-1-04; DEM 6-2010, f. 12-30-10, cert. ef. 1-1-11; DEM 1-2011(Temp), f. & cert. ef. 4-4-11 thru 9-27-11; DEM 5-2011, f. & cert. ef. 9-26-11

332-025-0022

Mother and Baby Care Practice Standards

(1) An LDM may:

- (a) Order and receive laboratory and ultrasound results;
- (b) Order and receive fetal surveillance testing and results.
- (c) Fit barrier methods of contraception, if qualified to fit barrier methods of contraception.

(2) For mother and baby care practice standards the agency and board adopt by reference the MANA core competencies, current version as approved by MANA. Reference <http://mana.org/manacore.html> for current version.

(3) In addition to and not in lieu of the MANA core competencies, an LDM must adhere to the following mother and baby care practice standards:

(a) Care During Pregnancy (Antepartum) — The LDM must:

- (A) Provide health care, support and information to the mother throughout pregnancy;
- (B) Determine the need for consultation or referral as appropriate;
- (C) Provide a mechanism that ensures 24 hour coverage for the practice;
- (D) Assess, identify, evaluate and support maternal and fetal well-being throughout the process of pregnancy;
- (E) Thoroughly educate and counsel mother regarding the childbearing cycle;
- (F) Identify preexisting conditions in a woman's health history that are likely to influence her well-being when she becomes pregnant;
- (G) Educate mother regarding nutritional requirements of pregnant mother and provide methods of nutritional assessment and counseling;
- (H) Educate mother regarding changes in emotional, psychosocial and sexual variations that may occur during pregnancy;

- (I) Identify and educate mother regarding environmental and occupational hazards for pregnant mother.
- (J) Educate mother regarding genetic factors that may indicate the need for counseling, testing or referral;
- (K) Educate mother regarding the growth and development of the unborn baby;
- (L) Identify and educate mother regarding indications for, risks and benefits of bio-technical screening methods and diagnostic tests used during pregnancy;
- (M) Educate mother regarding anatomy, physiology and evaluation of the soft and bony structures of the pelvis;
- (N) Exercise palpation skills for evaluation of the fetus and uterus;
- (O) Assess and educate mother regarding causes and treatment of the common discomforts of pregnancy;
- (P) Identify implications of and appropriate treatment for various infections, disease conditions and other problems that may affect pregnancy;
- (Q) Identify and educate of special needs of the Rh(D)-negative woman;
- (R) Begin fetal surveillance testing no later than 41 weeks and three days by arranging one or more of the following:
 - (i) Biophysical profile weekly and non-stress test bi-weekly;
 - (ii) Biophysical profile weekly and auscultated acceleration testing bi-weekly;
 - (iii) Amniotic fluid index and non-stress test bi-weekly; or
 - (iv) Amniotic fluid index and auscultated acceleration testing bi-weekly.
- (S) If the mother declines fetal surveillance testing listed in subsection (R) of this rule, the LDM must document refusal, initialed by the mother, and provide auscultated acceleration testing bi weekly beginning no later than 41 weeks and three days until delivery.
- (T) If the LDM is denied access to fetal surveillance testing listed in subsection (R) of this rule, the LDM must document the place, date, time, and name of individual who denied access in the mother's records. If access to fetal surveillance testing is denied, then the LDM must perform auscultated acceleration testing bi weekly beginning no later than 41 weeks and three days until delivery.

(U) When risk factors that could impair fetal or placental circulation are present at any time during the pregnancy, an LDM must obtain fetal surveillance testing when the risk factors are identified.

(V) If the mother declines fetal surveillance testing or if the LDM is denied fetal surveillance testing, an LDM must follow board approved practice standards for auscultated acceleration testing, including: utilizing the auscultated acceleration testing graph; following the procedure provided for the graph; and complying with interpretation requirements for the graph. Graph, procedure and interpretation requirements are available on the agency Web site at <http://egov.oregon.gov/OHLA/DEM/forms.shtml>.

(b) Care During Labor, Birth and Immediately Thereafter (Intrapartum) — the LDM must:

(A) Provide health care, support and information to the mother throughout labor, birth and the hours immediately thereafter;

(B) Determine the need for consultation or referral as appropriate;

(C) Make appropriate and ongoing risk assessment and document maternal and fetal status and response throughout labor;

(D) Evaluate maternal and fetal well-being during labor, birth and immediately thereafter, including relevant historical data;

(E) For mothers and babies without signs of risk factors, during the active phase of the first stage of labor, evaluate the fetal heart rate at least every 30 to 60 minutes, listening toward the end of a contraction and for at least 30 seconds after;

(F) For mothers and babies with risk factors, auscultate fetal heart tones more frequently than every 30 to 60 minutes and listen through contractions as indicated in the active stage of labor;

(G) Auscultate fetal heart tones approximately every 5 to 10 minutes or after every contraction, as indicated, with active pushing;

(H) Assess birthing environment, assuring that it is clean, safe and supportive, and that appropriate equipment and supplies are on hand;

(I) Assess emotional responses and their impact during labor, birth and immediately thereafter;

(J) Provide comfort and support measures during labor, birth and immediately thereafter;

(K) Evaluate fetal and maternal anatomy and their interactions as relevant to assessing fetal position and the progress of labor;

(L) Utilize techniques to assist and support the spontaneous vaginal birth of the baby and placenta;

(M) Assess and meet fluid and nutritional requirements during labor, birth and immediately thereafter;

(N) Assess and support maternal rest and sleep as appropriate during the process of labor, birth and immediately thereafter;

(O) Assess causes of, evaluate and treat variations that occur during the course of labor, birth and immediately thereafter;

(P) Provide appropriate support for the newborn's transition during the first minutes and hours following birth;

(Q) Evaluate and care for perineum and surrounding tissues; and

(R) Before the LDM leaves or the family is discharged, the placenta must be delivered and the mother's general condition, blood pressure, pulse, temperature, fundus, lochia, and ability to ambulate and urinate must be assessed. Mother's and baby's condition must be found to be within normal limits.

(c) Care After Delivery (Postpartum Care) — The LDM must:

(A) Provide health care, support and information to the mother throughout the postpartum period;

(B) Determine the need for consultation or referral as appropriate;

(C) Assess anatomy and physiology of the mother during the postpartum period;

(D) Educate mother regarding lactation support and appropriate breast care including evaluation of, identification of and treatments for problems with nursing;

(E) Evaluate and promote maternal well-being;

(F) Assess causes of, evaluate and treat maternal discomfort;

(G) Evaluate and educate emotional, psychosocial and sexual variations;

(H) Monitor and educate mother regarding maternal nutritional requirements during including methods of nutritional evaluation and counseling;

(I) Assess causes of, evaluate and treat problems arising during the postpartum period, consulting as necessary;

- (J) Provide family with written and verbal postpartum instructions; and
 - (K) Provide support, information and referral for family planning methods, as the individual woman desires.
- (d) Newborn Care — The LDM must:
- (A) Provide health care to the newborn;
 - (B) Provide support and information to parents regarding newborn care;
 - (C) Determine the need for consultation or referral as appropriate;
 - (D) Evaluate anatomy and physiology of newborn and support of the newborn's adjustment during the first days and weeks of life;
 - (E) Evaluate newborn wellness including relevant historical data and gestational age;
 - (F) Assess and educate the mother regarding nutritional needs of the newborn;
 - (G) Educate mother regarding state laws concerning indications for, administration of, and the risks and benefits of prophylactic bio-technical treatments and screening tests commonly used during the neonatal period;
 - (H) Educate mother regarding causes of, assessment of, appropriate treatment and emergency measures for newborn problems and abnormalities;
 - (I) Adhere to state guidelines for the administration of vitamin K and ophthalmic prophylaxis pursuant to ORS 433.306 and OAR 333-021-0800; and
 - (J) Ensure infant metabolic screening is performed and documented according to the Department of Human Services recommendations unless the mother declines, as provided ORS Chapter 432 and OAR 333-024-0205 through 0235.
- (4) Declined Procedure: In the event the mother refuses any testing or procedures required by administrative rule or recommended by the LDM, the LDM must document discussion with the mother of why the test or procedure is required or recommended, and document the mother's refusal of the test or procedures, including the mother's signature in the chart. In addition, the LDM must follow the requirements of ORS Chapter 432, 433.306, OAR 333-021-0800 and 333-024-0205 through 0235 when the mother declines administration of vitamin K or infant metabolic screening.

Stat. Auth.: 676.605, 676.615, 687.480 & 687.485

Stats. Implemented: 676.605, 676.615, 687.480 & 687.485

Hist.: DEM 1-1993(Temp), f. & cert. ef. 12-22-93; DEM 1-1994, f. & cert. ef. 6-15-94;

DEM 2-1998, f. 4-14-98, cert. ef. 4-15-98; DEM 1-1999(Temp), f. 9-1-99, cert. ef. 9-9-99

thru 2-29-00; DEM 2-1999, f. 12-17-99, cert. ef. 12-20-99; DEM 2-2000(Temp), f. 8-22-00, cert. ef. 8-22-00 thru 2-17-00; DEM 2-2000(Temp), f. 8-22-00, cert. ef. 8-22-00 thru 2-17-01; DEM 3-2000, f. 9-29-00, cert. ef. 10-1-00; DEM 1-2001(Temp), f. & cert. ef. 10-1-01 thru 3-29-02; Administrative correction 11-7-01; DEM 1-2002, f. 2-25-02 cert. ef. 3-1-02; DEM 1-2004, f. 6-29-04, cert. ef. 7-1-04; DEM 6-2010, f. 12-30-10, cert. ef. 1-1-11; DEM 1-2011(Temp), f. & cert. ef. 4-4-11 thru 9-27-11; DEM 5-2011, f. & cert. ef. 9-26-11

332-025-0030 [Renumbered to 332-026-0000]

332-025-0040 [Renumbered to 332-026-0010]

332-025-0050 [Renumbered to 332-026-0020]

332-025-0060 [Renumbered to 332-026-0030]

332-025-0070 [Renumbered to 332-025-0110]

332-025-0080 [Renumbered to 332-025-0120]

332-025-0100 [Renumbered to 332-025-0130]

332-025-0110

Records of Care Practice Standards

- (1) The LDM must maintain complete and accurate records of each mother and baby.
- (2) Records mean written documentation, including but not limited to:
 - (a) Midwifery care provided to mother and baby;
 - (b) Demographic information;
 - (c) Medical history;
 - (d) Diagnostic studies and laboratory findings;
 - (e) Emergency transport plan defined under OAR 332-025-0020;
 - (f) Informed consent and risk information documentation under OAR 332-025-0120;
 - (g) Health Insurance Portability and Accountability Act (HIPAA) releases;
 - (h) Description of the reasoning for transfer of care defined under OAR 332-025-0021 of the mother and baby;

- (i) Documentation of all consultations and recommendations from health care providers as defined under OAR 332-015-0000;
 - (j) Documentation of all consultations and recommendations regarding non-absolute risk factors from Oregon licensed health care providers as defined under OAR 332-025-0021;
 - (k) Documentation of any declined procedures under OAR 332-025-0022;
 - (l) Documentation of termination of care under OAR 332-025-0130; and
 - (m) Documentation that the patient disclosure form has been received by the mother under OAR 332-025-0020, including information regarding completion of the 40 hours of Initial Renewal Legend Drugs and Devices Training or the additional eight hours of Subsequent Renewal Continuing Education related to training in intravenous antibiotics for Group B Streptococcal prophylaxis.
- (3) Records must be maintained for no less than seven years. All records are subject to review by the agency.
- (4) All records must be legibly written or typed, dated and signed.
- (5) All records must include a signature or initial of the LDM.

Stat. Auth.: ORS 487.485 & 676.615

Stats. Implemented: ORS 687.425, 687.480, 687.485, 676.606 & 676.607

Hist.: DEM 6-2010, f. 12-30-10, cert. ef. 1-1-11; Renumbered from 332-025-0070 by DEM 5-2011, f. & cert. ef. 9-26-11; DEM 1-2014(Temp), f. 12-31-14, cert. ef. 1-2-15 thru 6-27-15; DEM 2-2015, f. & cert. ef. 7-1-15

332-025-0120

Informed Consent Practice Standards

- (1) Informed consent means the consent obtained following a thorough and easily understood explanation of the information to the mother or mother's guardian.
- (2) The explanation must be both verbal and written.
- (3) An LDM must document the verbal explanation and the written informed consent process in the client's record. Informed consent information must include the following:
 - (a) Definition of procedure or process;
 - (b) Benefits of procedure or process;

- (c) Risk(s) of procedure or process;
 - (d) Description of adverse outcomes;
 - (e) Risk of adverse outcomes; and
 - (f) Alternative procedures or processes and any risk(s) associated with them if the alternative procedures or processes are within the practice of midwifery.
- (4) An LDM must obtain mother's dated signature acknowledging she has received, reviewed, and understands the information, and has made an informed choice.

Stat. Auth.: ORS 487.485 & 676.615

Stats. Implemented: ORS 687.425, 687.480, 687.485, 676.606 & 676.607

Hist.: DEM 6-2010, f. 12-30-10, cert. ef. 1-1-11; DEM 2-2011(Temp), f. & cert. ef. 5-19-11 thru 11-15-11; Renumbered from 332-025-0080 by DEM 5-2011, f. & cert. ef. 9-26-11; DEM 6-2011(Temp), f. 10-14-11, cert. ef. 10-15-11 thru 4-11-12; DEM 1-2012(Temp), f. 3-1-12, cert. ef. 4-12-12 thru 9-30-12; DEM 3-2012(Temp), f. & cert. ef. 5-10-12 thru 9-30-12; DEM 5-2012, f. 8-31-12, cert. ef. 9-7-12

332-025-0125

Disclosure for Patients of Traditional Midwives

- (1) Pursuant to ORS 687.415 an individual who is acting as a traditional midwife, does not use legend drugs and devices, does not advertise as a midwife, and provides the required written disclosures to clients, may practice direct entry midwifery in this state without a license to practice direct entry midwifery.
- (2) Pursuant to ORS 687.415 a traditional midwife is prohibited from the following:
 - (a) Advertising that the person is a midwife; and
 - (b) Use of legend drugs and devices pursuant to ORS 687.493.
- (3) A traditional midwife must disclose the following information to clients both verbally and in writing when the mother initially comes into care using a Board adopted form that is located on the Office's website at <http://www.oregon.gov/OHLA/DEM/pages/index.aspx>:
 - (a) That the person does not possess a professional license issued by the state;
 - (b) That the person's education and qualification have not been reviewed by the state;
 - (c) That the person is not authorized to carry and administer potentially lifesaving medications;

(d) That the risk of harm or death to a mother or newborn may increase as a result of the information described ORS 687.415(2)(b)(C) (i) and (ii);

(e) A plan for transporting the client to the nearest hospital, as defined in ORS 442.015, if a problem arises during labor or childbirth;

(f) That the client will not have recourse through a complaint process;

(g) The types of midwives who are licensed by the state; and

(h) Signature from the patient that they have been given the information both in writing and verbally.

(4) The traditional midwife must also obtain a patient signature when the mother initially comes into care on the Board's adopted form containing the information described in subsection (3). A traditional midwife must retain a copy of the signed form in the patient record and make it available to HLO upon request.

Stat. Auth.: ORS 676.615, 676.616, 687.410, 687.415, 687.420, 687.425, 687.445, 687.480 & 687.493

Stats. Implemented: ORS 676.615, 676.616, 687.410, 687.145, 687.420, 687.425, 687.445, 687.480 & 687.493

Hist.: DEM 2-2014, f. 12-31-14, cert. ef. 1-1-15

332-025-0130

Practice Standards for Terminating Midwifery Care

(1) The procedure for terminating midwifery care in a non-emergent situation is as follows:

(a) Provide written notice no fewer than three business days as postmarked, unless the mother is in labor or during an emergency, at which time the LDM must continue to provide midwifery care until another provider assumes care;

(b) Notice must be sent to the last known address of the mother by certified mail, return receipt requested, as well as by regular mail.

(c) Document the termination of care in the mother's records.

(2) To terminate midwifery care in an emergency, the LDM must activate the 911 emergency system and transfer care to a licensee under ORS chapter 682.

(3) An LDM in the home setting may leave after transferring care to a licensee under ORS Chapter 682.

(4) If the mother refuses assistance from licensees under ORS chapter 682 the LDM must continually urge the mother to transfer care to a licensee under ORS Chapter 682 and may:

(a) Continue care to save a life; and

(b) Only perform actions within the technical ability of the LDM.

(5) If the mother loses consciousness, the LDM must activate the 911 emergency system and transfer care to a licensee under ORS Chapter 682.

Stat. Auth.: ORS 487.485 & 676.615

Stats. Implemented: ORS 687.425, 687.480, 687.485, 676.606 & 676.607

Hist.: DEM 6-2010, f. 12-30-10, cert. ef. 1-1-11; Renumbered from 332-025-0100 by DEM 5-2011, f. & cert. ef. 9-26-11

Public/Interest Parties Feedback

Communication Report

ITEMS FOR BOARD OF DIRECT ENTRY MIDWIFERY NEWSLETTER:

- Subject matter expert recruitment
- List of meeting dates and times for 2017, once approved
- News on continuing education classes at HLO, if that happens before end of the year
- Complaint process
- Rulemaking schedule that's in process
- Well woman care
- Confidentiality update
- HERC vs. DMAP vs. Board (on blog already)

UPDATE ON CONTINUING ED CLASSES:

- Took iLearn course administrator training
- Need to take training on creation of eLearning courses
- Have reached out to Karen Armstrong about teaching

TRADITIONAL MIDWIFE INFORMATION DISCLOSURE

Pursuant to Oregon Revised Statute (ORS) 687.415 an individual who is acting as a traditional midwife by practicing direct entry midwifery in this state without a license to practice direct entry midwifery, must provide both verbally and in writing the information contained in this disclosure statement to each client as outlined in Oregon Administrative Rule (OAR) 332-025-0125.

1. Client Name

LAST	FIRST	MI
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2. Traditional Midwife Information

I am registered with the OHA Center for Health Statistics to file birth records?

Yes No

TRADITIONAL MIDWIFE'S NAME: LAST	FIRST	MI
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MAILING ADDRESS

CITY	STATE	ZIP
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PHONE: <input type="checkbox"/> HOME <input type="checkbox"/> CELL	EMAIL
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3. Disclosures

As a person practicing as a traditional midwife in this state, I hereby disclose to the client named on this form the following:

- I do not possess a professional license to practice direct entry midwifery issued by the State of Oregon;
- My education and qualification have not been reviewed by the state;
- The risk of harm or death to you or your newborn may increase as a result of not possessing a professional license issued by the state, and by not having my education and qualifications reviewed by the state;
- I am not authorized to carry and administer potentially life-saving medications;
- As my client you will not have recourse through a complaint process;
- The types of midwives who are licensed by the State of Oregon are as follows:
 - LDM – Licensed Direct Entry Midwife
 - CNM – Certified Nurse-Midwife

In accordance with ORS 687.415 and OAR 332-025-0125(3)(e), I have determined the following plan for transporting the above named client to the nearest hospital, as defined in ORS 442.015, if a problem arises during labor or childbirth (***attach additional pages if necessary***):

By signing below, I am acknowledging that I have been provided the disclosure of information, both verbally and in writing, that is required of the midwife listed above pursuant to ORS 687.415 and OAR 332-025-0125.

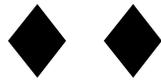
➡ Patient Signature:

Date:

A copy of this disclosure must be provided to the client. The traditional midwife providing the services must retain a copy of the signed form in the patient record and make it available to the HLO upon request.

A copy of this disclosure must be provided to the client

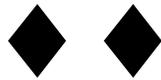
Executive Session



ORS 192.660(2)(f) for the purpose of considering
information or records exempt from public inspection.

Items for Board Action

Executive Session



ORS 192.660(2)(f) for the purpose of considering
information or records exempt from public inspection.

Items for Board Action

Other Board Business

