HEALTH LICENSING OFFICE
Kate Brown, Governor

Oregon Health Authority
1430 Tandem Ave. N.E. Suite 180
Salem, OR 97301
Phone: (503)378-8667
Fax: (503)585-9114
www.oregon.gov/oha/ph/hlo

WHO: **Health Licensing Office**
Board of Direct Entry Midwifery
1430 Tandem Ave. N.E. Suite 180, Salem, OR 97301
TELEPHONE CONFERENCE CALL ONLY

WHEN: **Thursday October 21, 2021 at 8 a.m.**

Due to the COVID-19 pandemic, the Health Licensing Office (Office) is closed to the public and not open for in-person attendance at the Board meeting. All audience members may attend the public meeting by telephone conference call. Telephone conference call instructions are provided below.

What is the purpose of the meeting?
The purpose of the meeting is to conduct board business. A copy of the agenda is printed with this notice. Please visit https://www.oregon.gov/oha/PH/HLO/Pages/Board-Direct-Entry-Midwifery-Meetings.aspx for current meeting information.

May the public attend open sessions?
Yes. A teleconference line is available for the public to attend the open sessions of the public meeting.

Telephone conference call instructions:

- Approximately five minutes prior to the start of the meeting dial (503) 934-3605 and enter the specific passcode listed on the agenda below. The passcode is different for each public meeting.
- You will be notified that you are connected to the conference call.
- The conference call line will stay connected for the duration of the meeting.
- For the courtesy of all participants on the call, keep your phone on mute during all times of the meeting, until your turn to speak during the Public and Interested Parties Feedback period.
- Email April Fleming at april.fleming@dhsoha.state.or.us stating you are logged in and whether or not you want to make public comment during the Public and Interested Parties Feedback period.

What if the board/council enters into executive session?
Prior to entering executive session, the board/council chairperson will announce the nature of and the authority for holding executive session. Board members, designated participants such as staff, and representatives of the news media shall be allowed to attend the executive session. All other audience members are not allowed to attend the executive session. Executive session would be held according to ORS 192.660.

Representatives of the news media who are interested in attending an executive session are asked to contact April Fleming at april.fleming@dhsoha.state.or.us prior to the meeting to make arrangements to attend Executive Session by telephone conference call.

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 April Fleming at April.fleming@dhsoha.state.or.us

Approval of Agenda

Health Licensing Office
Board of Direct Entry Midwifery
1430 Tandem Ave, N.E., Suite 180, Salem, OR 97301

TELEPHONE CONFERENCE CALL ONLY

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Thursday, October 21, 2021 at 8 a.m.

Conference call phone line number: (503)934-3605
Conference call passcode: 530340

1. **Call to Order**

2. **Items for Board Action**
   - ♦ Approval of Agenda
   - ♦ Approval of 2022 Board Meeting Dates
   - ♦ Approval of Chairperson
   - ♦ Approval of Courses in Disciplinary Case

3. **Reports**
   - ♦ Director Report
   - ♦ Licensing and Fiscal Statistical Reports
   - ♦ Regulatory Report
     -Subject Matter Experts Review - Investigations
   - ♦ Policy Report
     -Abnormal Fetal Surveillance Testing Discussion (IUGR)
     -Legend Drugs & Devices Continuing Education Committee Update
     -Birthing Center Rules Advisory Committee Update
   - ♦ COVID-19 Status Update

4. **Public/ Interest Parties Feedback**

5. **Executive Session:** Pursuant to ORS 192.660(2)(f) and ORS 676.595 for the purpose of considering information exempt from public disclosure. (to consider information or records that are exempt by law from public inspection)

6. **Items for Board Action**
   - ♦ Complaint or Deliberation/Decisions

7. **Other Board Business**

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

2022 Meeting Dates

HEALTH LICENSING OFFICE
Kate Brown, Governor

Oregon Health Authority

1430 Tandem Ave. NE, Suite 180
Salem, OR 97301-2192
Phone: (503)378-8667
Fax: (503)585-9114
www.oregon.gov/OHA/PH/HLO

2022 Meeting Dates

ISSUE

The Board of Direct Entry Midwifery (Board) must approve 2022 meeting times and dates. The Health Licensing Office proposes:

- 8 a.m. January 13
- 8 a.m. February 10 – full meeting
- 8 a.m. March 10
- 8 a.m. April 14
- 8 a.m. May 12
- 8 a.m. June 16 – full meeting
- 8 a.m. July 7
- 8 a.m. August 18
- 8 a.m. September 15
- 8 a.m. October 20 – full meeting
- 8 a.m. November 17

BOARD ACTION

The Board approves the 2022 meeting times and dates:

2022 Chairperson

HEALTH LICENSING OFFICE
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Chairperson– 2022

BACKGROUND AND DISCUSSION

Meredith Klein has served as chair for the Board of Direct Entry Midwifery (Board) during 2021.

ISSUE

In accordance with ORS 687.475 and OAR 332-010-0002 the Board must nominate and elect a chairperson for 2022.

Role of the chair in meetings

- Officially call the meeting to order.
- Keep order and impose any necessary restrictions for the efficient and orderly conduct of the meeting.
- Direct the "flow" of the meeting and to ensure the meeting is conducted in a professional manner. Some key points regarding meeting protocol include:
  - Board members wishing to speak must wait to be addressed by the chair.
  - Once addressed by the chair, the board member must state their last name for the record before speaking.
  - The chair guides members through the motion-making process.
  - If public comment is being accepted by the Board, audience members must wait to be addressed by the chair and state their full name and affiliation to the Board.
- Officially enter/exit executive session.
- Officially adjourn the meeting.

Role of the chair outside of meetings

- Collaborate with the director regarding the Board budget. The director may contact the chair to discuss the Board budget regarding revenue, expenditures and possible fee changes.
- Assist in generating meeting agendas. The board specialist or analyst may contact the chair to discuss the agenda for an upcoming meeting. The chair may be asked to comment on topics to be discussed and the format or order in which the topics should be presented at the meeting.

BOARD ACTION

The Board nominates and elects:

Chair:

Approval of Courses

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Disciplinary Case

BEFORE THE
STATE BOARD OF DIRECT ENTRY MIDWIFERY
HEALTH LICENSING OFFICE

In the Matter of:	)	**FINAL ORDER**
Laurie Perron Mednick	)	**BY DEFAULT**
	)	
License No.	)	
DEM-LD-10141215	)	
	)	
Respondent,	)	Agency File No. 18-8824

Under ORS 676.612(1), 687.420, 687.445, and 687.485, the State Board of Direct Entry Midwifery (the "Board"), with the assistance of and in consultation with the Health Licensing Office[1] ("HLO" or the "Office") is the State board charged with licensing and disciplining licensed direct entry midwives.

On July 9, 2021, the Board, Office, issued a Notice of Intent to Impose Discipline (Notice) in this matter. Respondent did not request a hearing. The Notice informed Licensee that in the event that Licensee did not request a hearing, the Board, Office, could issue a final order by default. The Notice also informed Licensee that in the event the Board, Office, issued a final order by default, the Board, Office, designates its file on this matter, including all materials submitted by Respondent, as the record for purposes of proving a prima facie case upon default. The Board, Office, now designates its file in this matter.

Now, therefore, after consideration of the relevant portions of the Office's file relating to this matter, the Board enters the following Findings of Fact, Conclusions of Law, and Final Order by Default:

PROPOSED FINDINGS OF FACT

1) At all relevant times, Respondent held Oregon Direct Entry Midwifery license DEM-LD-10141215 issued by the Office. Respondent also holds a midwifery license in Washington.

2) On or about June 7, 2017, Client began care for her first pregnancy at Nest Midwifery. At the time Respondent and DEM were partners and co-owners of Nest Midwifery and provided co-care of Client, however according to Respondent and DEM, Respondent identified as the secondary midwife. Client had been receiving prenatal care from Kaiser Permanente (Kaiser) and continued to obtain co-care from Kaiser throughout the remainder of her pregnancy.

3) On or about December 1, 2017, Client tested positive for Group Beta Streptococcus (GBS). GBS can be transferred from a birthing person to a fetus during the laboring and birthing process after the amniotic sac is broken. The risk of a birthing person transferring GBS to a fetus is higher if the birthing person's membranes are ruptured 18 hours or more before the fetus is born. GBS infection in a newborn can be life-threatening.

[1] As of July 1, 2014, the "Oregon Health Licensing Agency" (OHLA or Agency) became the "Health Licensing Office" (HLO or Office).

4) On or about December 4, 2017, Client signed Nest Midwifery GBS Informed Choice document and marked her choice to treat with prophylactic antibiotics. The document stated:

   4.1. There is increased risk of a newborn developing GBS infection if the mother's membranes are ruptured 18 or more hours.
   4.2. The CDC recommends treatment with antibiotics once labor has begun and repeated every four hours until birth.
   4.3. If midwife determines that a mother has a high risk of infection, transport will be advised.

5) On or about December 6, 2017, Respondent and DEM received Client's signed Nest Midwifery GBS Informed Choice document during a prenatal visit. Respondent and DEM informed Client that the 4-hour course of intrapartum antibiotic prophylaxis (IAP) would begin when Client was in active labor.

6) On or about December 13, 2017, at 37 weeks and 6 days gestation, during a prenatal visit with Respondent and DEM, Client fundal height was measured at 40 cm.

7) On or about December 20, 2017, at 38 weeks 6 days gestation, during a prenatal visit with Respondent and DEM, Client fundal height was measured at 41.5 cm.

8) On or about January 3, 2018, at 40 weeks and 6 days gestation, during a prenatal visit with Respondent and DEM, Client fundal height was measured at 43 cm. They discussed Client having an NST (Fetal Non-stress Test) and BBP (Biophysical Profile) at 41 weeks and 3 days gestation.

9) On or about January 6, 2018, at 41 weeks and 2 days gestation, DEM charted "Disc risks [with] post dates pregnancy." Post dates pregnancy is 42 weeks gestation or longer. There are elevated risks to a birthing person and fetus with a post dates pregnancy.

10) On or about January 9, 2018, Client had an NST and BBP at Kaiser. Test results show NST: reactive AFI: 15.8cm MVP: 4.49cm BPP: 8/8. Those test results were received by Nest Midwifery that same day and initialed by DEM.

11) On or about January 10, 2018, at 41 weeks and 6 days gestation, DEM attended the prenatal visit with Client. DEM charted Client's fundal height was measured at 44 cm. They discussed the NST and BBP performed at Kaiser the previous day. The results were described as reassuring.

12) On or about January 12, 2018, at 8:00 a.m., Client had an NST and BBP at Kaiser. Test results show NST: non-reactive AFI: 16.4cm MVP: 5.2cm BPP: 8/8. Baseline 160-170 bpm, two FHR accelerations in 20 minutes but zero sustained, and one audible deceleration to 80 bpm. The January 12, 2018, non-reactive NST with an audible deceleration to 80 bpm, is an abnormal fetal surveillance test and an absolute antenatal risk factor. Kaiser records indicate that Client was strongly urged to go via ambulance to hospital for further monitoring and assessment. A Kaiser MD discussed the risks of declining extended monitoring, including the risk of fetal death, with Client. Client verbalized understanding of those risks. Client called

DEM. According to DEM, Client said that Kaiser "didn't know what they were doing, she didn't believe them" that there was no variability and they want further monitoring. Following the phone call, Client signed "leaving against Medical advice" document after review by MD and acknowledgment of understanding of risks.

13) On or about January 12, 2018, later in the morning, Respondent and DEM conducted an AAT in Client's home. Respondent and DEM both described the AAT as reassuring with good variability. The AAT was conducted using a doppler. Respondent relied on the AAT to confirm fetus viability. Assessing beat to beat variability was needed to determine the viability of the fetus. It is not possible to determine beat to beat variability with a doppler. Respondent and DEM informed the HLO investigator that they made no attempts to view or obtain the Kaiser test results or talk to the doctor at Kaiser on January 12, 2018, or at any time before or during the Client's labor.

14) Respondent failed to maintain records of diagnostic studies and lab findings related to the January 12, 2018, NST and BBP performed at Kaiser.

15) On or about January 14, 2018, at a prenatal with DEM, Client, with postdates gestation, reported spontaneous rupture of membranes on January 14, 2018, at approximately 1:30 am. Client reported the fluid was straw colored. PROM (premature rupture of membranes) instructions were documented and given. Records contain no documented discussion of when to initiate IAP for GBS positive status at this time. DEM stated in an interview with an HLO investigator that she believed it had been standard of care to begin IAP at the onset of active labor, regardless of when a birthing person's membranes rupture. Respondent's belief described an incorrect standard of care.

16) Respondent and DEM were in contact about Client's labor during the approximate 56 hours from PROM through to the time active labor began.

17) On or about January 15, 2018, at 4 a.m., approximately 26 hours post PROM, Client reported concerns of decreased fetal movement. DEM arrived at Client's home and performed what she documented as an AAT "of sorts". Fetal heart tones (FHT) were documented as 132-144 with acceleration with movement to 160 and DEM deemed this as reactive. DEM told Client that they could go to the hospital at any time for induction or monitoring. DEM charted that they will rely on Client for intuition regarding baby well-being.

18) On or about January 15, 2018, at 2:10 p.m., DEM charted that Client was having contractions every four minutes lasting 1 minute. DEM charted she planned to check back in two hours to see if contraction pattern continues and that she wanted to be sure Client was in active labor before IAP administration.

19) On or about January 15, 2018, at 7:00 p.m., DEM charted that she had been with Client for 2 hours and Client was not in active labor.

20) On or about January 16, 2018, DEM received a text telling her that Client had rested and her contractions were now 5-8 minutes apart. DEM arrived at Client's home at 7:00 a.m. and charted that FHT were 144-160 and that Client was not in active labor yet. DEM noted no changes in ammonitic fluid, and no maternal fever.

21) On or about January 16, 2018, at 9:20 a.m., approximately 56 hours post PROM, DEM charted that Client was in active labor and that she would begin IAP administration for GBS positive status. Started IAP at a 30-minute rate at 9:25 a.m.
    21.1. 1:30 p.m., Started IAP second dose. FHT 156-172
    21.2. 2:00 p.m. Respondent arrived at Client's home.
    21.3. 2:00 p.m. FHT 156-180 in-between contraction. Baby in lower 0 to +1 station, 90% effaced 7 cm dilated. Amniotic fluid - midwives noted that the straw-colored particulate they have been seeing is now mocha in color. They did not believe that it was new meconium event.
    21.4. 4:25 p.m., Bloody show and yellow
    21.5. 5:30 p.m., IAP administration 30-minute rate.
    21.6. 9:00 p.m. FHT 140s some meconium in fluid
    21.7. 9:35 p.m. IAP administration.
    21.8. 10:30 p.m. Vaginal exam (VE) by Respondent and DEM (8.5 hours from last VE). Midwives charted 0 station, 90% effaced 7 cm dilated. Asynclitic with overriding sagittal sutures.

22) IAP administration should have been initiated prior to 9:25 a.m. on January 16, 2018, approximately 56 hours since PROM, for Client, who was GBS positive and had consented to IAP administration.

23) At least by this 9:20 a.m. point, Client, who was GBS positive and had prolonged rupture of membranes, should have been provided informed consent regarding the timing of IAP initiation. Respondent failed to provide Client, who was GBS positive and had prolonged rupture of membranes, with informed consent specific to when to initiate IAP and the risks of waiting to initiate IAP until 56 hours post PROM.

24) A change in the color of a birthing person's fluids can be from meconium in amniotic fluid. Meconium is a fetus's or baby's first stools. A fetus's release of meconium, noted through a change in fluid color, can be a sign of fetal intolerance or distress.

25) Client was considered to have the risk factor of advanced maternal age. Advanced maternal age means a person 35 years or older at the time when giving birth. There can be various risks associated with advanced maternal age, including labor complications and adverse labor outcomes for the birthing person and fetus.

26) On or about January 17, 2018, 12:30, a.m., FHT had been recorded in Client's chart approximately every 30 minutes between 10:30 p.m. and 12:30 a.m. as being between 144 and 156.

27) On or about January 17, 2018, 12:30 a.m., Client had failed to progress in her labor, which at least by this point, increased the risks to Client and fetus, including infection and death. According to the midwife's charts Client stated she needed to rest. Because Client presented a lack of cervical change, prolonged rupture of membranes, and long labor, they discussed the need to reassess the cervix for change at 1:45 a.m., after a rest break. Current maternal and fetal heart tones were described as normal. Client wanted to continue to attempt to

correct malpositioned baby. They discussed the possibility of transport to Kaiser if no change.

27.1. 1:40 a.m. IAP administration.

27.2. No FHT were recorded from 12:30 a.m. to 1:45 a.m.

27.3. 1:45 a.m., maternal pulse 80, BP 120/80, temp 97.4 f, Contractions had a pattern of spaced out then a cluster of painful contractions, FHT 132-144 with no decals.

27.4. 2:10 a.m., VE showed cervix was at 7-8 cm. The baby's head felt flexed but still asynclitic. Midwives discussed with Client the need to find more cervical progress. Midwives offered Client the option to try movement and position changes for 2 hours, as long as vitals and FHT remain normal or she could transport for pain relief. Client wanted to try for two more hours and then transport if no changes.

28) At least by this 2:10 a.m. point, Client presented with layered risk factors, also called cumulative risks or cumulative risk factors, which increased the risks to Client and fetus, including infection and death. Respondent failed to recognize or act on Client presenting cumulative risk factors, including advanced maternal age, nonreassuring fetal surveillance test(s), postdates gestation, prolonged rupture of membranes, failure to progress, meconium stained fluid, and GBS positive status.

29) At least by this 2:10 a.m. point, Respondent failed to provide Client with informed consent regarding the elevated risks to Client and fetus from the cumulative risks or failed to maintain complete and accurate records of informed consent, or both.

30) At least by this 2:10 a.m. point, Client should have been provided informed consent for the individual risk factors of advanced maternal age, prolonged rupture of membranes, failure to progress, and meconium stained fluid. Respondent failed to provide Client with such informed consent or failed to maintain complete and accurate records of informed consent, or both, for each of those individual risk factors.

31) On or about January 17, 2018, 2:40 a.m. FHT 110-120 before, during and after contractions. Midwives noted a baseline decrease.

31.1. 2:53 a.m. FHT 60. Midwives activated 911.

31.2. 3:04 a.m. Emergency medical technicians arrived. Client transported to the hospital.

32) On or about January 17, 2018, at 3:14 a.m., upon arrival at the hospital a fetal demise was confirmed.

CONCLUSIONS OF LAW[2]

1. Respondent acted negligently, incompetently, or departed from or failed to conform to standards of practice in performing services or practicing direct entry midwifery, or any combination thereof, when she relied on the January 12, 2018, AAT without a plan for follow-up of additional testing, a violation of and a cause for discipline under ORS 676.612(2)(j).

[2] Each violation is a distinct and separate independent basis to impose the penalty.

2. Respondent acted negligently, incompetently, or departed from or failed to conform to standards of practice in performing services or practicing direct entry midwifery, or any combination thereof, by failing to attempt to obtain or obtain the results of the January 12, 2018, NST and BBP performed at Kaiser, a violation of and a cause for discipline under ORS 676.612(2)(j).

3. By failing to maintain records of diagnostic studies and lab findings related to the January 12, 2018, NST and BBP performed at Kaiser, Respondent violated OAR 332-025-0110(1), (2)(d), a cause for discipline under ORS 676.612(2)(n), and a failure to conform to standards of practice and a cause for discipline under ORS 676.612(2)(j).

4. Respondent acted negligently, incompetently, or departed from or failed to conform to standards of practice in performing services or practicing direct entry midwifery, or any combination thereof, by failing to initiate IAP, with a client who consented to IAP administration, until January 16, 2018, at 9:25 a.m., approximately 56 hours of PROM when Client was GBS positive, a violation of and a cause for discipline under ORS 676.612(2)(j).

5. Respondent failed to provide Client, who was GBS positive and had prolonged rupture of membranes, with informed consent regarding the timing of IAP initiation, a violation of OAR 332-025-0022(3)(b)(A), a cause for discipline under ORS 676.612(2)(n), or failed to maintain complete and accurate records of informed consent, a violation of 332-025-0110(1), a cause for discipline under ORS 676.612(2)(n), or both, either of which is also a failure to conform to standards of practice and a cause for discipline under ORS 676.612(2)(j).

6. Respondent acted negligently, incompetently, or departed from or failed to conform to standards of practice in performing services or practicing direct entry midwifery, or any combination thereof, by failing to recognize or act on Client presenting cumulative risk factors, including advanced maternal age, nonreassuring fetal surveillance test(s), postdates gestation, prolonged rupture of membranes, failure to progress, meconium stained fluid, and GBS positive status, a violation of and a cause for discipline under ORS 676.612(2)(j).

7. Respondent failed to provide Client with informed consent regarding the elevated risks to Client and fetus from the cumulative risks, a violation of OAR 332-025-0022(3)(b)(A), a cause for discipline under ORS 676.612(2)(n), or failed to maintain complete and accurate records of informed consent, a violation of 332-025-0110(1), a cause for discipline under ORS 676.612(2)(n), or both, either of which is also a failure to conform to standards of practice and a cause for discipline under ORS 676.612(2)(j).

8. For each of the individual risk factors of advanced maternal age, prolonged rupture of membranes, failure to progress, and meconium stained fluid, Respondent failed to provide Client with informed consent, a violation of OAR 332-025-0022(3)(b)(A), a cause for discipline under ORS 676.612(2)(n), or failed to maintain complete and accurate records of informed consent, a violation of 332-025-0110(1), a cause for discipline under ORS 676.612(2)(n), or both, and a failure to conform to standards of practice and a cause for discipline under ORS 676.612(2)(j).

OPINION

Under OAR 332-025-0021(2)(a)(S) and OAR 332-025-0021(1)(a) any abnormal fetal surveillance test is an absolute antenatal risk and would require a midwife to plan for transfer of care of Client and an in-hospital birth. On January 12, 2018, the Respondent's client had a non-reactive NST with an audible deceleration to 80 bpm. This was an abnormal fetal surveillance test. Respondent was aware Kaiser had performed tests. Without the test results, Respondent did not have information essential to determining the direction of Client's care, the need to transfer care, and the risks to Client and Client's fetus. A reasonably, prudent, careful, and skillful Oregon midwife would have attempted to obtain or obtain the results of the tests. When Respondent failed to attempt to obtain or obtain the test results, the Respondent acted negligently, incompetently, or departed from or failed to conform to standards of practice in performing services or practicing direct entry midwifery, or any combination thereof, a violation under ORS 676.612(2)(j).

Respondent and DEM conducted an AAT in Client's home later that morning. Respondent and DEM both described the AAT as reassuring with good variability. The AAT was conducted using a doppler. Respondent relied on the AAT to confirm fetus viability. Assessing beat to beat variability is needed to determine the viability of the fetus. It is not possible to determine beat to beat variability with a doppler. It was not appropriate to rely on the AAT in this case without a plan for follow-up of additional testing because the AAT could not determine the viability, the beat to beat variability, of the fetus. Respondent did not have information essential to determining the direction of Client's care and the risks to Client and Client's fetus. A reasonably, prudent, careful, and skillful Oregon midwife would not have relied on the AAT without a plan for follow-up of additional testing. Respondent acted negligently, incompetently, or departed from or failed to conform to standards of practice in performing services or practicing direct entry midwifery, or any combination thereof, when she relied on the AAT without a plan for follow-up of additional testing, a violation under ORS 676.612(2)(j).

Under OAR 332-025-0110(1), (2)(d), a midwife is required to maintain records of diagnostic studies and lab findings. When the Respondent failed to obtain and maintain the records related to the January 12, 2018, NST and BBP performed at Kaiser, Respondent violated OAR 332-025-0110(1), (2)(d) and failed to conform to standards of practice under ORS 676.612(2)(j).

The Client was GBS positive and had consented to IAP administration. GBS infection in a newborn can be life-threatening. The risk of a birthing person transferring GBS to a fetus is higher if the birthing person's membranes are ruptured 18 hours or more before the fetus is born. Respondent waited approximately 56 hours after Client's membranes ruptured before beginning IAP administration. Respondent acted contrary to the standards of care that a reasonably, prudent, careful, and skillful Oregon midwife would exercise in this situation. Respondent acted negligently, incompetently, or departed from or failed to conform to standards of practice in performing services or practicing direct entry midwifery, or any combination thereof, a violation of ORS 676.612(2)(j).

As a licensed direct entry midwife, the Respondent was required under OAR 332-025-0022(3)(b)(A) to provide health care support and information to the client. Under OAR 332-025-0110(1) the Respondent is required to maintain complete and accurate records of informed consent. The Client, who was GBS positive and had prolonged rupture of membranes, should have been provided informed consent regarding the timing of IAP initiation and the risks of waiting to initiate IAP until 56 hours post PROM. At least by 9:20 a.m. on January 16, 2018, Respondent failed to provide Client with informed consent regarding the timing of IAP initiation, a violation of OAR 332-025-0022(3)(b)(A), or Respondent failed to maintain complete and accurate records of informed consent, a violation of 332-025-0110(1), or both, either of which is also a failure to conform to standards of practice under ORS 676.612(2)(j).

The Client presented with layered risk factors, also called cumulative risks or cumulative risk factors, including advanced maternal age, nonreassuring fetal surveillance test(s), postdates gestation, prolonged rupture of membranes, failure to progress, meconium-stained fluid, and GBS positive status. The cumulation of these individual risk factors increased the risks to Client and fetus, including the risks of infection and death. A reasonably, prudent, careful, and skillful Oregon midwife would have recognized and acted on these cumulative risk factors. By not recognizing or acting on these cumulative risk factors the Respondent acted negligently, incompetently, or departed from or failed to conform to standards of practice in performing services or practicing direct entry midwifery, or any combination thereof, a violation of ORS 676.612(2)(j).

As a licensed direct entry midwife, the Respondent was required under OAR 332-025-0022(3)(b)(A) to provide health care support and information to the client. Under OAR 332-025-0110(1) the Respondent is required to maintain complete and accurate records of informed consent. At least by 2:10 a.m. on January 17, 2018, Client presented with cumulative risk factors and should have been provided informed consent regarding the risks of presenting with cumulative risk factors. Additionally, Respondent should have provided Client with individual informed consent for each of the risk factors of advanced maternal age, prolonged rupture of membranes, Client's failure to progress, and meconium-stained fluid. Respondent failed to provide Client with informed consent specific to presenting with cumulative risk factors and failed to provide informed consent for four individual risks, each a violation of OAR 332-025-0022(3)(b)(A), or Respondent failed to maintain complete and accurate records of those informed consents, a violation of 332-025-0110(1), or both, either of which is also a failure to conform to standards of practice under ORS 676.612(2)(j).

ORDER

Pursuant to ORS 687.445, 676.612(1), (2), and 676.992(1) and (2), the Board of Direct Entry Midwifery hereby ORDERS:

1. Assess a civil penalty in the amount of $5,000 against Laurie Perron Mednick ("Respondent").[3] Payment of $2,000 of that civil penalty will be stayed if the Respondent completes the following classes within 12 months of the issuance of this Final Order and provides to the Board evidence of completion:

    1.1. Respondent completes a Board approved class on charting. Respondent is responsible for identifying courses and submitting the courses to HLO for approval by the Board. Respondent can fulfill this requirement with a course taken since January 18, 2018.

    1.2. Respondent completes a Board approved class on risk assessment. Respondent is responsible for identifying courses and submitting the courses to HLO for approval by the Board. Respondent can fulfill this requirement with a course taken since January 18, 2018.

    1.3. Respondent completes a Board approved class on GBS screening, management, and antibiotic prophylaxis. Respondent is responsible for identifying courses and submitting the courses to HLO for approval by the Board. Respondent can fulfill this requirement with a course taken since January 18, 2018.

    1.4. Respondent completes a Board approved class on fetal surveillance. Respondent is responsible for identifying courses and submitting the courses to HLO for approval by the Board. Respondent can fulfill this requirement with a course taken since January 18, 2018.

2. Suspend Respondent's license until she provides evidence of completion of the requirements listed in 1.1 through 1.4.

3. After the suspension in number two ends, place Respondent on probation until Respondent provides evidence to the Board of completion of the below requirements with a Board approved supervisor, who practices direct entry midwifery outside of Respondent's midwifery practice, for the first three births after issuance of this Final Order. Suspend Respondent's license if she fails to provide sufficient evidence of completion within 18 months of the issuance of this Final Order.

    3.1. 35 week chart review and risk assessment with Respondent's Board approved supervisor. The review must be based on the Oregon Midwifery Council's intention of incident review (found at: https://oregonmidwiferycouncil.org/wp-content/uploads/2019/10/OMC-peer-review-charter.pdf). Review of the charts with the Board approved supervisor must be live—in person, by phone or via a different electronic medium that allows for live review; a written review is not sufficient to fulfill this requirement.

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[3] If the final civil penalties and costs are not timely paid, interest on the final penalties and costs will accrue at the statutory rate of interest, currently 9% pursuant to ORS 82.010.

3.2. Supervision, with Respondent's Board approved supervisor in attendance, during intrapartum period.

3.3. Review with Respondent's Board approved supervisor of direct entry midwifery care provided to client at the conclusion of client's care.

3.4. Respondent not supervise other individuals practicing midwifery.

4. Respondent is responsible for any fees or costs associated with these requirements, including any fees or costs associated with classes, supervision, and chart review.

DATED 9/15/2021

Meredith Klein, LDM
Chair, Board of Direct Entry Midwifery

Issuance and mailing date: September 15, 2021

RIGHT TO JUDICIAL REVIEW

Appeal Rights: You have the right to appeal this order to the Oregon Court of Appeals pursuant to ORS 183.482. To appeal you must file a petition for judicial review with the Court of Appeals within 60 days from the day this order was served on you. If this order was personally delivered to you, the date of service is the day you received the Order. If this Order was mailed to you, the date of service is the day it was *mailed,* not the day you received it. If you do not file a petition for judicial review within the 60-day time period, you will lose your right to appeal.

CERTIFICATE OF COMPLETION

LAURIE PERRON MEDNICK

has successfully completed this
Midwifery Wisdom Collective program
and has earned 12 CEU's from MEAC

DEFENSIVE CHARTING SEMINAR

September 2021, ONLINE

M1920-103-0430DE

meac
midwifery education accreditation council

AUGUSTINE COLEBROOK, CPM, MA
Instructor

MIDWIFERY WISDOM
COLLECTIVE
midwiferywisdom.com

8 CONTACT HOURS
ATTENDANCE/AWARD CERTIFICATE
DISTANCE LEARNING

Laurie Perron Mednick

Name & Identification Number (Last 4 digits of SS#)

Has earned a total of 8 contact hours of continuing education for

Fetal Assessment In Labor

taught by Holly Scholles, MA, CPM, LDM

offered via Distance Education at www.HiveCE.com

Completed on: February 28, 2019

Course taken at: www.HiveCE.com
Verify attendance: jesica@HiveCE.com

From: Kelsey Fisher, OMC Secretary omcsecretary@gmail.com
Subject: CEU's
Date: Dec 5, 2020 at 8:55:31 AM
To: Laurie Mednick laurie@nest-midwifery.com

Laurie,

Attached is your certificate for the online Risk Assessment Class on 12/4/2020.

Kelsey Fisher
Oregon Midwifery Council Secretary
omcsecretary@gmail.com
971.444.2641

OREGON MIDWIFERY COUNCIL

This certifies that Laurie Perron Mednick attended

has attended the following workshop on December 4, 2020

Title	Instructor(s)	Contact hours
Risk Assessment for Midwives	Silke Akerson CPM, LDM	3

AUTHORIZED BY

TOTAL CONTACT HOURS OBTAINED 3

Julia Bailey, OMC CEU Coordinator

motherled

Certificate Of Completion

Laurie Perron Mednick

Completed the Continuing Education Requirements

Group B Strep Training

Midwives Association of Alaska approved

Course 1201-A

Class Date: 08/29/2021 Issuer: Lena Morgan, CDM Motherled

FAX

Nest Midwifery, LLC
Laurie Perron Mednick, CPM, LM
Melissa Gordon-Magnus, CPM, LM
503 449-4465
www.nest-midwifery.com

To: HLO
Fax number: (503) 370-9004

From: Nest Midwifery
Fax number: (480) 772-4995

Date: 9/28/21

Regarding:
Case 18-8824

Nest Midwifery Phone (503) 449-4465

Case 18-8824

Laurie Perron Mednick DEM-LD-10141215

26618 NE 29th Ave

Ridgefield, WA 98642

(503)449-4465

Requirements of Final Order, 1.1-1.4

Please Note: This fax may contain private medical health information that is protected by federal law. If the receiver of the fax is not the intended recipient, they should immediately notify the sender of the error and destroy the entire contents of the sent fax without perusal. Any violation or misuse of protected health information is punishable by Federal law.

Sent from my iPhone

Director Report

COVID-19
Update

This is an official

CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network
September 29, 2021, 12:00 PM ET
CDCHAN-00453

COVID-19 Vaccination for Pregnant People to Prevent Serious Illness, Deaths, and Adverse Pregnancy Outcomes from COVID-19

Summary
The Centers for Disease Control and Prevention (CDC) recommends urgent action to increase Coronavirus Disease 2019 (COVID-19) vaccination among people who are pregnant, recently pregnant (including those who are lactating), who are trying to become pregnant now, or who might become pregnant in the future. CDC strongly recommends COVID-19 vaccination either before or during pregnancy because the benefits of vaccination outweigh known or potential risks. As of September 27, 2021, more than 125,000 laboratory-confirmed COVID-19 cases have been reported in pregnant people, including more than 22,000 hospitalized cases and 161 deaths.[1] The highest number of COVID-19-related deaths in pregnant people (n=22) in a single month of the pandemic was reported in August 2021. Data from the COVID-19-Associated Hospitalization Surveillance Network (COVID-NET) in 2021 indicate that approximately 97% of pregnant people hospitalized (either for illness or for labor and delivery) with confirmed SARS-CoV-2 infection were unvaccinated.[2] In addition to the risks of severe illness and death for pregnant and recently pregnant people, there is an increased risk for adverse pregnancy and neonatal outcomes, including preterm birth and admission of their neonate(s) to an intensive care unit (ICU). Other adverse pregnancy outcomes, such as stillbirth, have been reported. Despite the known risks of COVID-19, as of September 18, 2021, 31.0% of pregnant people were fully vaccinated before or during their pregnancy.[3] In addition, there are racial and ethnic disparities in vaccination coverage for pregnant people. Healthcare providers should communicate the risks of COVID-19, the benefits of vaccination, and information on the safety and effectiveness of COVID-19 vaccination in pregnancy. Healthcare providers should strongly recommend that people who are pregnant, recently pregnant (including those who are lactating), who are trying to become pregnant now, or who might become pregnant in the future receive one of the authorized or approved COVID-19 vaccines as soon as possible.

Background
COVID-19 vaccination is recommended for pregnant people. CDC recommends COVID-19 vaccination for all people aged 12 years and older, including people who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future.[4] CDC recommendations align with those from professional medical organizations serving people who are pregnant, including the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine. Accumulating data provide evidence of both the safety and effectiveness of COVID-19 vaccination in pregnancy. CDC strongly recommends COVID-19 vaccination either before or during pregnancy, because the benefits of vaccination for both pregnant persons and their fetus/infant outweigh known or potential risks. Getting a COVID-19 vaccine can prevent severe illness, death, and pregnancy complications related to COVID-19.

COVID-19 vaccination coverage for pregnant people remains low. Despite recommendations for vaccination, uptake of COVID-19 vaccination by pregnant people has been lower than that of non-pregnant people.[5] In addition, vaccination coverage for pregnant people differs by race and ethnicity, with vaccination coverage being lowest for non-Hispanic Black pregnant people (15.6%) as of September 18, 2021.[3] Although the proportion of fully vaccinated pregnant people has increased to 31.0% (as of

September 18, 2021), the majority of pregnant people remain unprotected against COVID-19, and significant disparities exist in vaccination coverage by race and ethnicity.

Pregnant and recently pregnant people with COVID-19 are at increased risk of severe illness, death, and pregnancy complications. Pregnant and recently pregnant people with COVID-19 are at increased risk for severe illness when compared with non-pregnant people. Severe illness includes illness that requires hospitalization, intensive care unit (ICU) admission, mechanical ventilation, or extracorporeal membrane oxygenation (ECMO), or illness that results in death. Although the absolute risk is low, compared with non-pregnant symptomatic people, symptomatic pregnant people have more than a two-fold increased risk of requiring ICU admission, invasive ventilation, and ECMO, and a 70% increased risk of death.[6] Pregnant people with COVID-19 are also at increased risk for preterm birth and some data suggest an increased risk for other adverse pregnancy complications and outcomes, such as preeclampsia, coagulopathy, and stillbirth, compared with pregnant people without COVID-19.[7-10] Neonates born to people with COVID-19 are also at increased risk for admission to the neonatal ICU.[9-11] In addition, although rare, pregnant people with COVID-19 can transmit infection to their neonates; among neonates born to women with COVID-19 during pregnancy, 1–4% of neonates tested were positive by rRT-PCR.[12,13]

Recommendations

CDC recommends urgent action to help protect pregnant people and their fetuses/infants. CDC recommends urgent action to accelerate primary vaccination for people who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future. Efforts should specifically address populations with lower vaccination coverage and use approaches to reduce racial and ethnic disparities. CDC recommends ensuring tailored, culturally responsive, and linguistically appropriate communication of vaccination benefits. In addition, pregnant people should continue to follow all recommended prevention measures and should seek care immediately for any symptoms of COVID-19. Healthcare providers should have a low threshold for increased monitoring during pregnancy due to the risk of severe illness.

Recommendations for Public Health Jurisdictions

- Continue and increase efforts to reach and partner with communities to encourage and offer vaccination to people who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future.
- Leverage resources to promote vaccine equity: COVID-19 Vaccine Equity for Racial and Ethnic Minority Groups.
    - Include focused efforts to increase vaccination coverage in pregnancy among people from racial and ethnic minority groups.
- Encourage healthcare providers to offer and recommend COVID-19 vaccination to their patients and community members who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future.
- Work with community partners and employers to make vaccination easily accessible for unvaccinated populations, including those who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future.
- Continue to implement additional prevention strategies where SARS-CoV-2 transmission is high and vaccination coverage is low, including in groups at increased risk, such as pregnant people.
- Continue to monitor community transmission and vaccination coverage levels and focus vaccine efforts on populations with low coverage.
- Disseminate and communicate information to key partners about vaccination coverage, risks posed by the highly transmissible Delta variant, and local transmission levels. Partner and share messaging with programs serving pregnant and recently pregnant people.

- Communicate accurate information about COVID-19 vaccines, respond to gaps in information, and confront misinformation with evidence-based messaging from credible sources. For example, there is currently no evidence that any vaccines, including COVID-19 vaccines, cause fertility problems in women or men.

Recommendations for Healthcare Providers

- Ensure all clinical staff are aware of the recommendation for vaccination of people before and during pregnancy and the serious risks of COVID-19 to pregnant and recently pregnant people and their fetuses/infants.
- Increase outreach efforts to encourage, recommend, and offer vaccination to people who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future. A strong recommendation from a healthcare provider is a critical factor in COVID-19 vaccine acceptance and can make a meaningful difference to protect the health of pregnant and recently pregnant people and their fetuses/infants from COVID-19.
- For healthcare providers who see patients who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future:
    - Review patients' COVID-19 vaccination status at each pre- and post-natal visit and discuss COVID-19 vaccination with those who are unvaccinated.
    - Reach out to your patients with messages encouraging and recommending the critical need for vaccination.
    - Remind patients that vaccination is recommended even for those with prior COVID-19 infections. Studies have shown that vaccination provides increased protection in people who have recovered from COVID-19.
    - Support efforts to ensure people receiving the first dose of an mRNA COVID-19 vaccine (i.e., Pfizer-BioNTech, Moderna) return for their second dose to complete the series as close as possible to the recommended interval.
        - Consider a booster dose in eligible pregnant persons.[4]
    - Communicate accurate information about COVID-19 vaccines and confront misinformation with evidence-based messaging from credible sources. For example, there is currently no evidence that any vaccines, including COVID-19 vaccines, cause fertility problems in women or men.
- Become a COVID-19 vaccine provider and vaccinate patients during their visit. More information can be found at How to Enroll as a COVID-19 Vaccination Provider.

For More Information

- Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Approved or Authorized in the United States
- COVID-19 Vaccines While Pregnant or Breastfeeding
- COVID-19 Vaccines for People Who Would Like to Have a Baby
- COVID-19 among Pregnant and Recently Pregnant People
- COVID Data Tracker
    - Vaccination Among Pregnant People
    - Data on COVID-19 during Pregnancy: Severity of Maternal Illness
- Toolkit for Pregnant People and New Parents
- Building Confidence in COVID-19 Vaccines

References

1. COVID Data Tracker. Data on COVID-19 during Pregnancy: Severity of Maternal Illness. (accessed September 27, 2021)
2. COVID-19-Associated Hospitalization Surveillance Network (COVID-NET) (unpublished data)
3. COVID Data Tracker. Vaccinations Among Pregnant People. (accessed September 27, 2021)
4. CDC Interim Clinical Considerations for Use of COVID-19 Vaccines. (accessed September 27, 2021)
5. Razzaghi H, et al. COVID-19 Vaccination Coverage Among Pregnant Women During Pregnancy — Eight Integrated Health Care Organizations, United States, December 14, 2020–May 8, 2021. *MMWR*. 2021:70(24);895–899.
6. Zambrano L, et al. Update: Characteristics of Symptomatic Women of Reproductive Age with Laboratory-Confirmed SARS-CoV-2 Infection by Pregnancy Status — United States, January 22–October 3, 2020. *MMWR*. 2020:69(44);1641–1647.
7. Ko JY, DeSisto CL, Regina M Simeone RM, et al. Adverse Pregnancy Outcomes, Maternal Complications, and Severe Illness Among US Delivery Hospitalizations With and Without a Coronavirus Disease 2019 (COVID-19) Diagnosis. *Clinical Infectious Diseases*. 2021;73(Supplement_1):S24–S31.
8. Jering KS, Clagget BL, Cunningham JW, et al. Clinical Characteristics and Outcomes of Hospitalized Women Giving Birth With and Without COVID-19. JAMA Intern Med. 2021;181(5):714-717. doi:10.1001/jamainternmed.2020.9241
9. Allotey J, et al. Clinical manifestations, risk factors, and maternal and perinatal outcomes of coronavirus disease 2019 in pregnancy: living systematic review and meta-analysis. *BMJ* 2020;370:m3320. (Published 01 September 2020)
10. Villar J, et al. Maternal and Neonatal Morbidity and Mortality Among Pregnant Women With and Without COVID-19 Infection: The INTERCOVID Multinational Cohort Study. *JAMA Pediatr*. 2021;175(8):817-826. doi:10.1001/jamapediatrics.2021.1050.
11. Woodworth KR, et al. Birth and Infant Outcomes Following Laboratory-Confirmed SARS-CoV-2 Infection in Pregnancy — SET-NET, 16 Jurisdictions, March 29–October 14, 2020. *MMWR*. 2020:69(44);1635–1640.
12. Olsen EO, et al. SARS-CoV-2 infections among neonates born to women with SARS-CoV-2 infection: maternal, pregnancy and birth characteristics. (pre-print accessed September 27, 2021)
13. Mullins E, Hudak ML, Banerjee J, et al. Pregnancy and neonatal outcomes of COVID-19: coreporting of common outcomes from PAN-COVID and AAP-SONPM registries. *Ultrasound Obstet Gynecol*. 2021;57(4):573-581. doi:10.1002/uog.23619

The Centers for Disease Control and Prevention (CDC) protects people's health and safety by preventing and controlling diseases and injuries; enhances health decisions by providing credible information on critical health issues; and promotes healthy living through strong partnerships with local, national, and international organizations.

Categories of Health Alert Network messages:

Health Alert	Requires immediate action or attention, highest level of importance
Health Advisory	May not require immediate action; provides important information for a specific incident or situation
Health Update	Unlikely to require immediate action; provides updated information regarding an incident or situation
HAN Info Service	Does not require immediate action; provides general public health information

##This message was distributed to state and local health officers, state and local epidemiologists, state and local laboratory directors, public information officers, epidemiologists, HAN coordinators, and clinician organizations##

Licensing and Fiscal Statistical Report

Oregon Health Authority

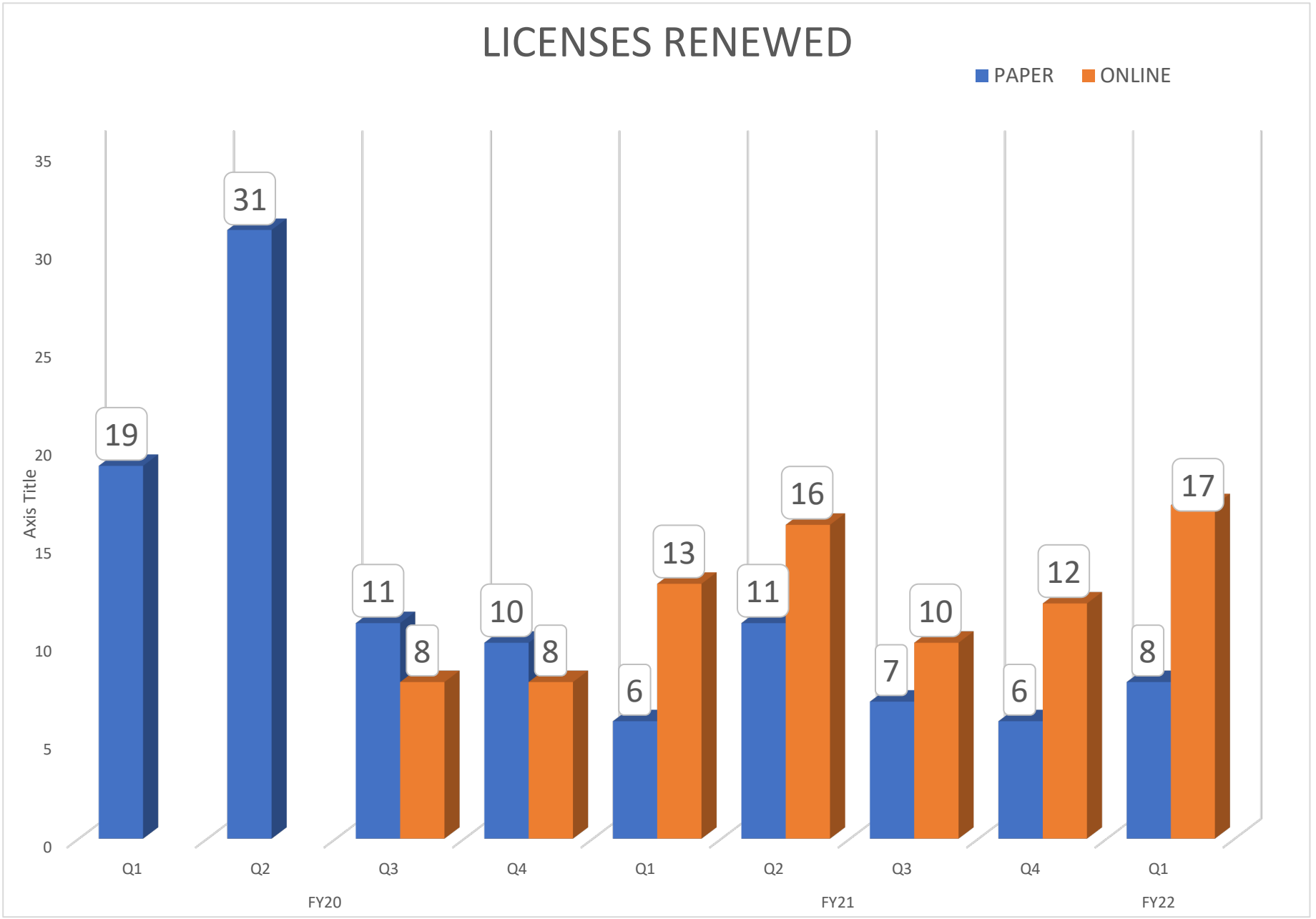
Health Licensing Office

Protecting the health, safety and rights of Oregon consumers

Board of Direct Entry Midwifery

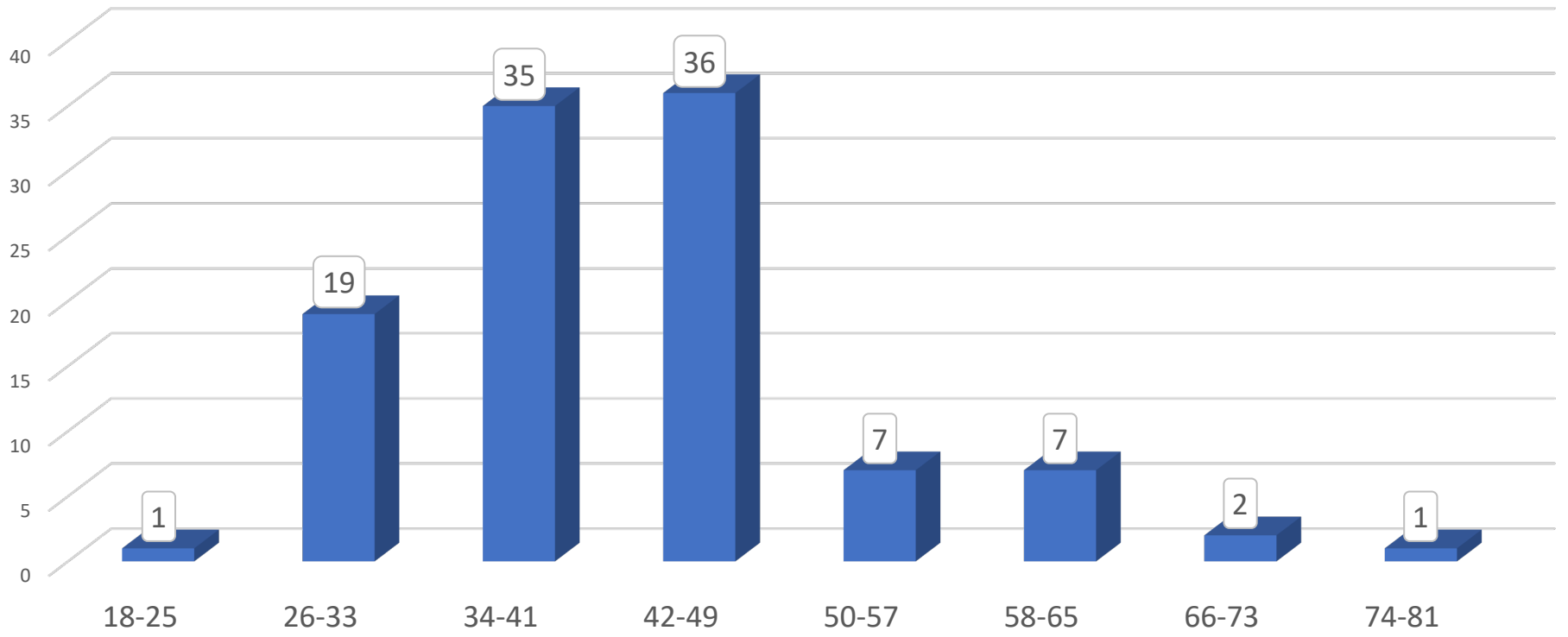
Board Report

TOTAL ISSUED	FY20	5	FY21	19	FY22	1	TOTAL	28
	7/1/19 - 6/30/20		7/1/20 - 6/30/21		7/1/21 - 6/30/22			

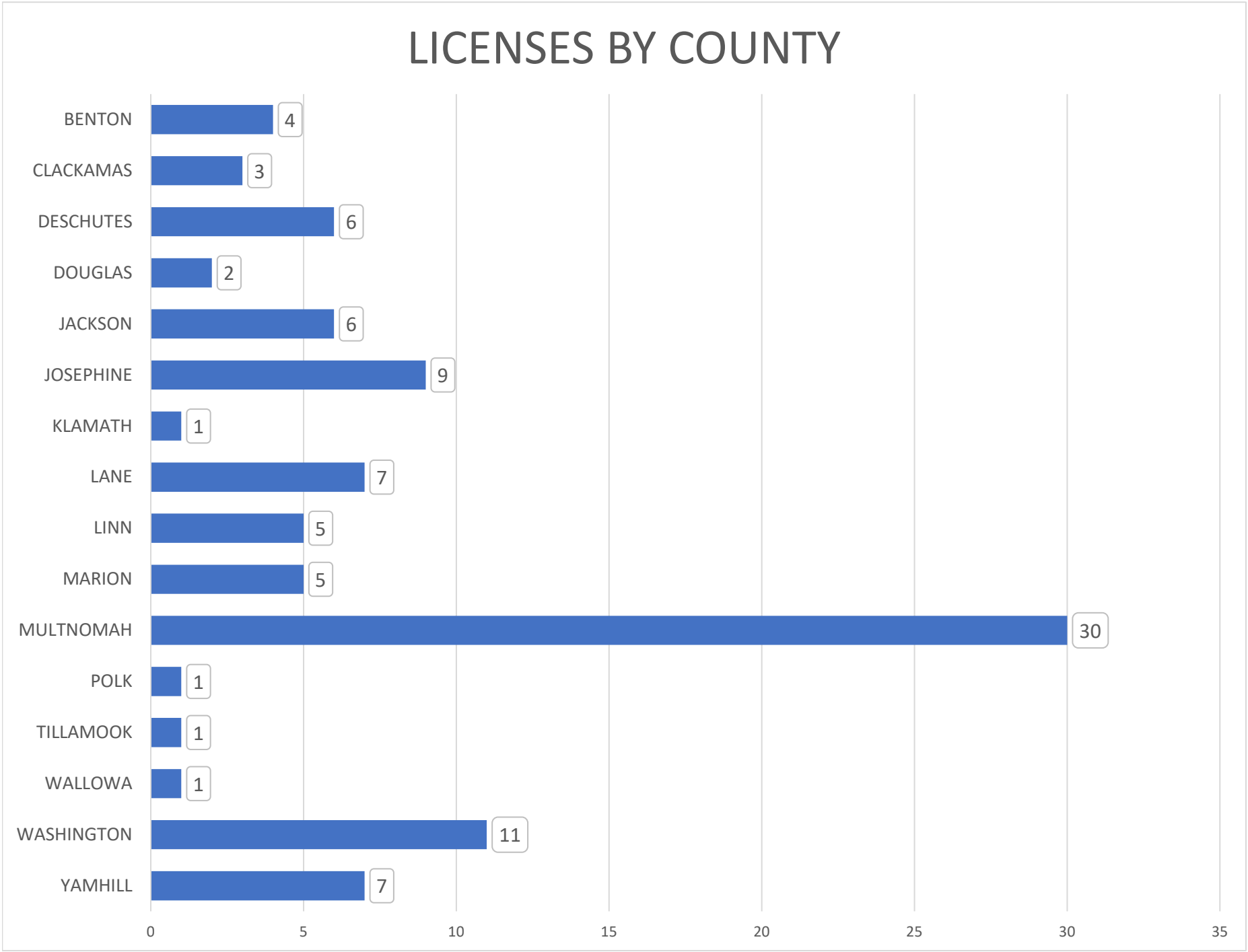


TOTAL RENEWED	FY20 87	FY21 81	FY22 25	TOTAL 193
	7/1/19 - 6/30/20	7/1/20 - 6/30/21	7/1/21 - 6/30/22	

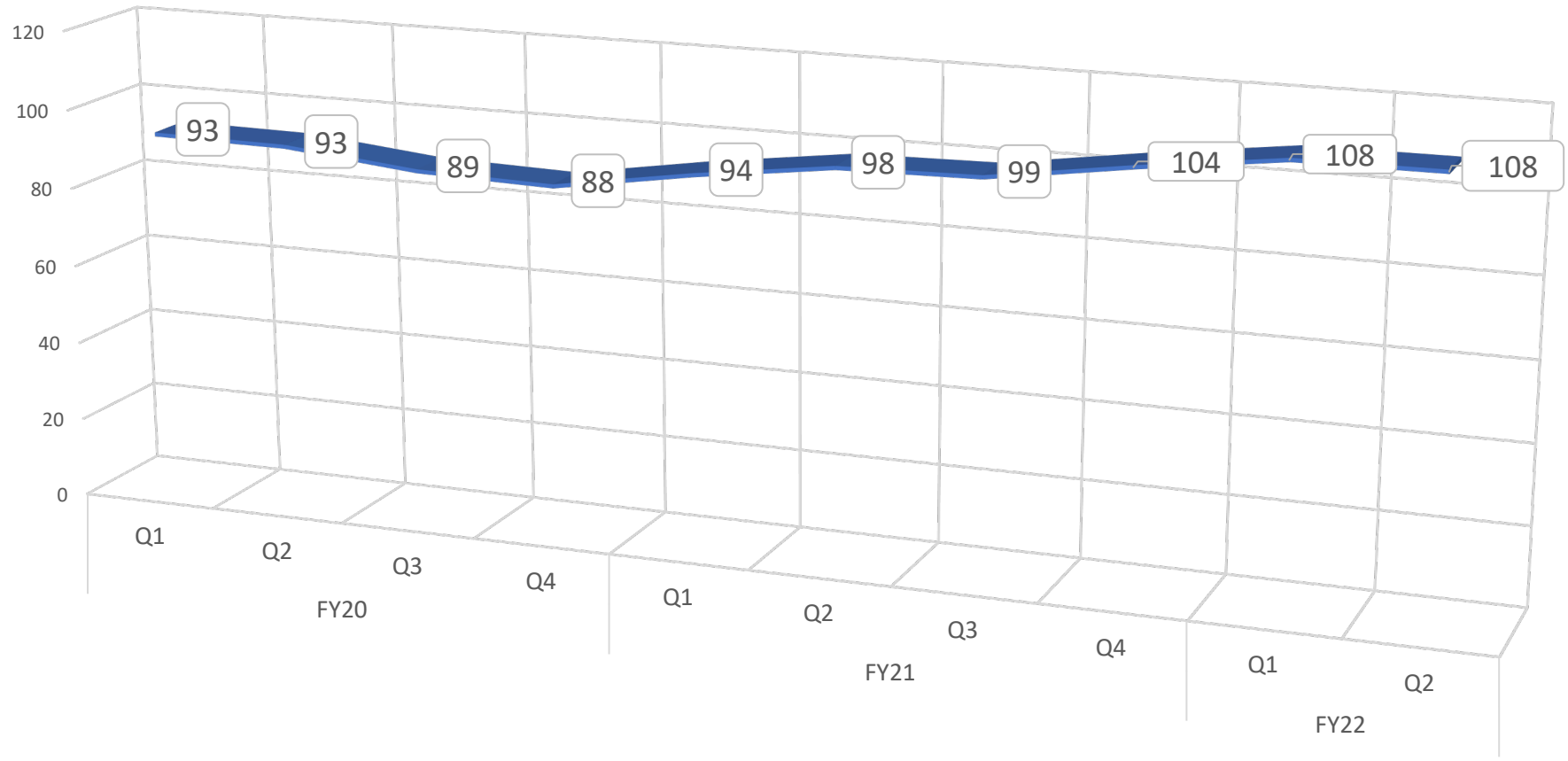
LICENSES BY AGE



TOTAL	108


LICENSES BY COUNTY
BENTON
4
CLACKAMAS
3
DESCHUTES
6
DOUGLAS
2
JACKSON
6
JOSEPHINE
9
KLAMATH
1
LANE
7
LINN
5
MARION
5
MULTNOMAH
30
POLK
1
TILLAMOOK
1
WALLOWA
1
WASHINGTON
11
YAMHILL
7
0
5
10
15
20
25
30
35

LICENSE VOLUME TRENDS



FY20	FY21	FY22
7/1/19 - 6/30/20	7/1/20 - 6/30/21	7/1/21 - 6/30/22

BOARD OF DIRECT ENTRY MIDWIFERY

Biennium	< 2015-17		< 2017-19 >		2019-21 >	
State Fiscal Year	**2017** *(Jul15-Jun16)*	**2018** *(Jul17-Jun18)*	**2019** *(Jul18-Jun19)*	**2020** *(Jul19-Jun20)*	**2021** *(Jul20-Jun21)*	**2022** *(Jul21-Current*)*
Beginning Cash Balance	**($275,149)**	**($321,340)**	**($345,088)**	**($393,791)**	**($379,818)**	**($438,885)**
Revenues	$64,378	$56,893	$56,275	$74,025	$59,853	$22,902
Expenditures	$110,569	$80,641	$104,978	$60,052	$118,920	$2,889
Net Operations *(Rev - Exp Only)*	*($46,191)*	*($23,748)*	*($48,703)*	*$13,973*	*($59,067)*	*$20,013*
Ending Cash Balance *(Beg Cash + Rev - Exp)*	**($321,340)**	**($345,088)**	**($393,791)**	**($379,818)**	**($438,885)**	**($418,872)**

*Updated with September 2021 Actuals AJC

Regulatory Report

HEALTH LICENSING OFFICE
1430 Tandem Ave. NE, Suite 180
Salem, OR 97301-2192
Phone: (503) 378-8667 | Fax: (503) 370-9004
Email: hlo.info@dhsoha.state.or.us
Web: www.oregon.gov/oha/ph/hlo

Board Report

Board of Direct Entry Midwifery

10/18/2021

CASES BY LICENSE TYPE AND OPEN/CLOSED STATUS				
	2017	2019	2021	Grand Total
OPEN				
Direct Entry Midwife w/ Legend Drugs endorsement	0	3	6	9
TOTAL	**0**	**3**	**6**	**9**
CLOSED				
Direct Entry Midwife w/ Legend Drugs endorsement	72	16	7	95
UNLICENSED Midwifery	9	2	1	12
TOTAL	**81**	**18**	**8**	**107**
Grand Total	**81**	**21**	**14**	**116**

COMPLAINTS BY TYPE				
	2017	2019	2021	Grand Total
Licensing Concern	11	3	1	15
Services Provided	70	18	13	101
Grand Total	**81**	**21**	**14**	**116**

COMPLAINANTS BY TYPE	
ANONYMOUS	2
CLIENT	5
OTHER	109
TOTAL	116

Subject Matter Expert

~

Disciplinary Case

HEALTH LICENSING OFFICE

Oregon Health Authority

1430 Tandem Ave. NE, Suite 180
Salem, OR 97301-2152
Phone: (503)378-8667
Fax: (503)585-9114
www.oregon.healthoregon.org/hlo

Date: April 15, 2021

To: Oregon Licensed Direct Entry Midwives

From: Bob Bothwell, Regulatory Manager

Subject: Recruitment for Midwifery Subject Matter Experts

The Health Licensing Office (HLO) is seeking licensed direct entry midwives to serve as subject matter experts (SMEs) for complaint investigations. A SME is an independent contractor who assists in investigations of and cases against Oregon direct entry midwives. SMEs may be called upon to assist the HLO in various ways, such as: working with a HLO investigator when investigating licensees, providing opinions about community standards, and competently testifying during hearings.

SMEs must be able to review and analyze client records, interview witnesses and licensees, testify at hearing, and draft investigatory reports. SMEs must also be knowledgeable about direct entry midwifery community standards. The ability to knowledgeably apply community standards to facts is essential. SMEs must be able to respectfully interact with individuals holding different points of view.

At a minimum, SMEs must:

- Hold an active midwifery license in Oregon,
- Have maintained an active midwifery license for the past five years; and
- Be in good standing with no current or pending disciplinary action.

SMEs are compensated at a rate of $65 per hour, including any necessary travel time. If interested in becoming a SME, please contact Bob Bothwell at robert.bothwell@dhsoha.state.or.us, or by calling (503) 373-2097.

Emilia Smith, LDM, CPM, LM, IBCLC

7306 SE Mill Street | Portland, OR 97215 | 503.805.1143 | megtaleena@gmail.com

Professional Experience

Rosehip Midwifery, Portland, OR
Primary Midwife, June 2015-present
Student Midwife, January 2012-May 2015

Oregon Midwifery Council
Portland Regional Representative, August 2020-present
Advocacy Council member, August 2020-present

Birthingway College of Midwifery, Portland, OR
Midwifery Program Faculty Member, September 2016-December 2019
Developed curriculum and syllabi and taught:

- *Fetal Assessment* - A course covering methods for evaluating fetal well-being, including monitoring and analyzing fetal heart tones using a Doppler or fetoscope, fetal movement monitoring, ultrasound, the Auscultated Acceleration Test (AAT), the Non-Stress Test (NST), the Biophysical Profile (BPP), Amniotic Fluid Index (AFI), and other methods.
- *Postpartum* - A course covering fetal anatomy and physiology, fetal transformation, newborn examination and age assessment, neonatal procedures, behavioral states, infant postpartum assessment, care and complications, maternal assessment and care, maternal postpartum complications, and postpartum emotional disorders.
- *Introduction to Breastfeeding Theory* - A course detailing infant and maternal anatomy and physiology and common complications, their assessment and treatment options.
- *Breastfeeding Education & Counseling* - A course detailing prenatal and postpartum breast/chestfeeding education both in a private and group consult/class settings.

Lactation Program Faculty Member, March 2016-December 2018
Developed curriculum and syllabi and taught:

- *Maternal Complex Breastfeeding Situations* - A course covering a variety of complicated physiologic and psychosocial scenarios including: breast surgery; nipple issues; genetic disorders; Cesarean birth; milk production; drug interactions; socio economic issues; grief; family transition; eating disorders, and Perinatal Mood Disorders.

- *Pregnancy & Birth Impacts on Breastfeeding* - A course examining the effects of pregnancy and birth on breast/chestfeeding, specifically looking at the anatomy and physiology of fetal development, maternal health and its effect on the fetus, the fetal environment, the impact of birth on the immediate postpartum, and the impact of birth related interventions on breast/chestfeeding.

Sisu Lactation, Portland, OR
Lactation Consultant, January 2014-present

Symphony Association, Portland, OR
Director of Education & Community Engagement, November 2005-March 2008

- Oversight and implementation of all Oregon Symphony Education & Community Engagement programs, which reach 60,000 children & adults from 300+ schools and 16 counties annually
- Development and management of $1.7 million budget
- Collaborative work with professional musicians, Oregon Symphony Board of Directors, 35 member administrative staff, teachers, students, volunteers, funders, Arts Education colleagues and community members across the state
- Oversight and management of Education & Community Engagement Coordinator, Education & Community Engagement Assistant and 45+ volunteers.

Education & Community Engagement Coordinator, July 2004-November 2005

Credentials

- Licensed Direct Entry Midwife (LDM), Oregon
- Certified Professional Midwife (CPM), North American Registry of Midwives
- Licensed Midwife (LM), Washington
- International Board Certified Lactation Consultant (IBCLC)
- Neonatal Resuscitation Program (NRP) certified
- CPR and AED Program certified

Education

Birthingway College of Midwifery, Portland, OR
Bachelor of Science in Midwifery, May 2015

Lewis & Clark College, Portland, OR
Bachelor of Arts in Music – Musicology & Vocal Performance, with honors, cum laude, May 2003

- Awarded American Association of University Women S*enior Woman of the Year Award*, 2003

Heather Hack-Sullivan
6738 SE 62nd Ave.
Portland, OR 97206
Tel. 503-504-0885
Fax 888-317-5548
www.rosehipmidwifery.com

Credentials

- Licensed Direct Entry Midwife in Oregon (LDM)
- Certified Professional Midwife (CPM) by the North American Registry of Midwives
- Neonatal Resuscitation Program Provider
- CPR and AED Program certified

Education

- Bachelor of Science degree in Midwifery from Birthingway College of Midwifery in Portland, OR—received December 2005
- Associate of Applied Science in Early Childhood Education from Mt. Hood Community College in Gresham, OR—received June 1993

Memberships and Affiliations

- Oregon Midwifery Council
- Midwives Alliance of North America
- North American Registry of Midwives
- Citizens for Midwifery

Experience

Midwifery

Sept. 2000-Oct. 2001	labor and birth doula
Jan. 2001-Aug. 2005	apprentice midwife with Alameda Clinic
Jan. 2003-Aug. 2005	apprentice midwife with A Woman's Way Midwifery
Sept. 2005-Sept. 2006	assistant midwife with Right At Home Midwifery
July 2005-Dec. 2005	midwife with Bellyfruit Midwifery
Aug. 2005-Dec. 2007	owner/midwife of Rosehip Midwifery
Jan. 2008-Oct. 2010	co-owner/midwife with Balanced Birth Midwifery
Dec. 2010-present	owner/midwife of Rosehip Midwifery

Teaching

1998-2000	instructor of Infancy Module at Birthingway College of Midwifery
2000-present	childbirth education instructor
2003-2005	assistant instructor of Gynecology and Basic Skills at Birthingway College of Midwifery
2006-2017	instructor of Prenatal Skills at Birthingway College of Midwifery
2006-2018	instructor of Postpartum Skills at Birthingway College of Midwifery

2006-2018 instructor of Infancy at Birthingway College of Midwifery

Early Childhood Education

1991-1993 student teacher at Mt. Hood Community College Child Development Center-Gresham, OR and Rockwood Therapeutic Head Start-Portland, OR
1993-1995 teacher at New Mexico Institute of Mining and Technology Child Care Center-Socorro, NM
1995-1996 director of New Mexico Institute of Mining and Technology Child Care Center-Socorro, NM
1996-1997 teacher at Mt. Hood Community College Child Care Center-Gresham, OR
1997-1999 in-home child care services-Portland, OR

Administrative

2017-present Midwifery Program Coordinator and Doula Program Coordinator at Birthingway College of Midwifery

Elizabeth Baer, CPM, LDM
1550 Post St
Lebanon, OR 97355
541-223-4454

Relevant Education

National Midwifery Institute – Graduated 2014

- This was a three year midwife training program that covered maternal health, prenatal and postpartum care, birth, breastfeeding, and newborn care through six weeks

DONA Birth Doula training – 2010

WIC Breastfeeding Peer Counselor training 2002

Advanced Life Suppport in Obstetrics certification (through the American Academy of Family Physicians - 2015

NRP (neonatal resuscitation) Training and Certification: 2011, 2013, 2015, 2017, 2019, 2021

CPR Certification: 2011, 2013, 2015, 2017, 2019, 2021

Professional Memberships or Organizations

Family Connections LBCC Social/Emotional SPARK Group - Joined April 2020

Certified Professional Midwife, Licensed Direct Entry Midwife since 2014

2013 MANA Conference Program Chair- MANA Conference Program Committee

Midwives Alliance of North America – Member

Oregon Midwifery Council – Member

La Leche League – volunteered in 2001

Relevant Experience

Midvalley Birthing Services, co-owner since Jan. 2016

- Has accumulated many continuing education hours beyond what is required for licensure, including in topics like cultural competency, professional development, infant issues, nutrition
- Attended over 500 births to date

Linn Local Advisory Committee for Intercommunity Health Network, served 2014-16

CNY Doula Connection – Founder 2010

WIC Breastfeeding Peer Counselor - 2002-2005

Elizabeth Baer Biography
Received by email on 10/8/2021

I am a Certified Professional Midwife (Oregon Licensed Direct Entry Midwife) and homeschooling mom of five. Our five children were all born into the hands of midwives, the first in a hospital, the next two at freestanding birth centers, and the next two at home. My husband and I grew up in Baltimore, Maryland and briefly lived in Syracuse, New York, prior to settling in Oregon's MidValley.

In 2011, I enrolled in the National Midwifery Institute. For my clinical training, I was able to apprentice at a freestanding birth center, a birth clinic in Haiti, and a home birth midwifery practice.

I started my own home birth practice in the spring of 2013, merged with MidValley Birthing Services in 2016, which grew into a beautiful group practice.

I love learning and regularly attend continuing education events, including things like Birth Emergency Skills Training, Advanced Life Support in Obstetrics, MANA conferences, Midwifery Today Conferences, regional midwifery conferences, and CPR and neonatal resuscitation training. I would be honored to serve as a subject matter expert if selected.

Liz Baer CPM LDM

CURRICULUM VITAE

Holly Scholles
4997 SW Normandy Place
Beaverton, Oregon 97005
971/404-9155

EDUCATION

Master of Arts in Anthropology (Biocultural) (ABD), Emory University, Atlanta, Georgia. 1990.
Master of Arts in Anthropology (Social), University of Texas at Austin, Texas. 1988.
Bachelor of General Studies (Social Sciences), University of Texas at Tyler, Texas. 1984.
Apprenticeship in Midwifery with Houston Midwife Education. 1977-78.

CREDENTIALS

Certified Professional Midwife (CPM), North American Registry of Midwives, 1996 to present
Licensed Direct-Entry Midwife (LDM), State of Oregon, 1993 to present
Certified Instructor, Biodynamic Resuscitation of the Newborn (BRN), 2006 to present
Professional Certification, Oregon Midwifery Council, 1993
Professional Certification, Association of Texas Midwives, 1987

FELLOWSHIPS, SCHOLARSHIPS AND GRANTS

Emory University Graduate Fellowship in Anthropology and Full Tuition Scholarship. 1988-1992
Mellon Foundation Research Grant 1991
Mike Harvey Scholarship, University of Houston. 1975-1977.

POSITIONS HELD

1993 – present	Founder and President, Birthingway College of Midwifery, Portland, Oregon
1985 – present	Consultant (clinical, legal), educator, and speaker.
1978 – present	Direct-entry Midwife in private, independent practice
2004 – 2012	Board of Directors, Midwifery Education Accreditation Council. Treasurer 2007-2009; President 2010-2011.
2008-10;1999-2001	President, Oregon Midwifery Council
2007 – 2009	Board of Directors, Academic Consortium for Complementary and Alternative Health Care
2006 – 2009	Education Committee Chair, Midwives Alliance of North America

2001 – 2008	Vice Chair, Oregon Board of Direct-entry Midwifery
1992 – 1995	Educator, Women's Services Department. Providence Medical Center, Portland, Oregon
1989	Teaching Assistant. Medical Anthropology. Emory University, Peter J. Brown, Supervisor
1986-88	Executive Director. The Association of Texas Midwives. Austin, Texas.
1986	Teaching Assistant. Introduction to Cultural Anthropology. The University of Texas at Austin. Ira Buchler, Supervisor
1979	Founder, Association of Texas Midwives.

SELECTED PUBLICATIONS

2006 Midwifery Model of Care – Phase II: Midwife Education. *Midwifery Today*. Spring 2006:78:66.

1988 When Surgeons Deliver Babies. *Texas Midwifery* 4(3/4):2-3.

1988 Midwifery in Texas and the Use of Informed Choice. Unpublished Master's Thesis. Austin, TX: The University of Texas at Austin.

1988 Compromise in Human Mating Strategies. *Southern Anthropologist* 16(3):14-31.

1987 A Summary of Alternative Birth Research in the United States. *Texas Midwifery* 2(1):4-6.

INVITED LECTURES and PAPER PRESENTATIONS

List available upon request

Policy Report

Abnormal Fetal Surveillance Testing Discussion (IUGR)

Legend Drugs & Devices Continuing Education Committee Update

HEALTH LICENSING OFFICE
Kate Brown, Governor

Oregon Health Authority
1430 Tandem Ave. NE, Suite 180
Salem, OR 97301-2192
Phone: (503) 378-8667
Fax: (503) 585-9114
Email: hlo.info@dhsoha.state.or.us
Website: www.oregon.gov/oha/ph/hlo

Date: September 24, 2021

To: The Board of Direct Entry Midwives

From: Cerynthia Murphy, Qualification Analyst

RE: September 23, 2021 – Legend DD Committee Meeting Report

On April 15, 2021, the Board of Direct Entry Midwives (Board) tasked the Health Licensing Office (HLO) with assembling an Education Committee (EC) to review the Legend Drugs and Devices Initial Continuing Education Program (LDDICEP) to determine which requirements must be completed to obtain licensure in Oregon. The EC will be tasked with reviewing:

- Education completed at in state and out-of-state schools
- Other state licensure, including previous experience
- Methods to verify education and experience
- Additional educational requirements, including supervisory requirements

On September 23, 2021, the EC met to discuss the Board's tasks and came up several recommendations; the EC will be holding meetings in 2021-2022 to prepare documentation to support the recommendations, which will be presented to the full Board for approval upon their completion. The EC recommendations are as follows:

Competencies

Create standardized competencies for individuals wanting to obtain licensure in Oregon, no matter what educational pathway an individual chooses, including attending a MEAC accredited or Pre-accredited educational institution, completing training through the NARM PEP process, or training or education obtained in another state.

Skills Examination

Create a standardized skills examination, which must be completed and passed prior to a licensed direct entry midwife (LDM) administering Legend Drugs and Devices in Oregon; verification for completing and passing the skills examination must be submitted upon the LDM's first renewal in addition to completing and passing the skills examination and providing verification for their alternating subsequent renewals.

The skill examination would be administered through a Board approved entity, which includes, but is not limited to, a MEAC accredited or pre-accredited educational institution, the Oregon Midwifery Council, or other qualified individuals.

The skills examination must be administered by a board approved entity or individual; the individual administering the skills examination must not be the same individual who provided the training or education.

Written Examination

Create a standardized written examination, which must be completed and passed prior to a licensed direct entry midwife (LDM) administering Legend Drugs and Devices in Oregon; verification for completing and passing the written examination must be submitted upon the LDM's first renewal in addition to completing and passing the written examination and providing verification for their alternating subsequent renewals.

The written examination would be administered through Workday Oregon and must be monitored by a board approved entity or individual; the individual monitoring the written examination must not be the same individual who provided the training or education.

The EC members will be providing the HLO with documentation and information by October 6, 2021, which will be used by HLO to prepare a draft of the standardized competencies and the written and skills examination. The EC designated Catherine Akerson Bailey and Gregg Ramirez as the EC members the HLO will work with directly when preparing drafts of the standardized competencies and examination in preparation for the EC meeting on December 9, 2021.

The HLO will be working directly with legal counsel to ensure recommendations by the EC align with the Boards authority.

The HLO will keep the Board apprised of the EC's progress during regularly scheduled Board meetings.

LEGEND DRUGS & DEVICE COMMITTEE SCHEDULE

HEALTH LICENSING OFFICE
Board of Direct Entry Midwifery

Date	Action	Time
April 15, 2021	Board meeting – approve schedule & recommend committee membership	8 am
May 13, 2021	Board meeting	8 am
June 17, 2021	Board meeting – update on Legend Drugs & Devices Committee	8 am
July 8, 2021	Board meeting	8 am
August 19, 2021	Board meeting – update on Legend Drugs & Devices Committee	8 am
August 26, 2021	Legend Drugs & Devices Committee - CANCELLED	10 am
September 8, 2021	Board meeting – CANCELED	8 am
September 23, 2021	Legend Drugs & Devices Committee	10 am
October 21, 2021	Board meeting	8 am
October 28, 2021	Legend Drugs & Devices Committee	10 am
November 18, 2021	Board meeting – update on Legend Drugs & Devices Committee	8 am
December 9, 2021	Legend Drugs & Devices Committee	10 am
January 13, 2022	Board meeting – update on Legend Drugs & Devices Committee	8 am

In order to limit the exposure and spread of the COVID-19 virus and adhere to the Governor's social distancing measures the Health Licensing Office (Office) is prohibiting in-person attendance at the meetings. All audience members may attend the public meeting by telephone conference call. Telephone conference call instructions are provided below.

All audience members are expected to keep phones **muted** until the public and interested parties feedback period.

Instructions:
Approximately five minutes prior to the start of the meeting please follow the directions listed below:

- Dial 1(877)336-1828 and enter the following participants pass code: 4111788 to be connected to the meeting. This phone line will stay connected for the duration of the meeting.
- The teleconference system will notify you that you are connected. For the record, Office staff will do a roll call of all audience members prior to and after the Executive Sessions.

Audience members are asked to send email to April Fleming at april.fleming@dhsoha.state.or.us stating they are logged into the telephone conference call and whether they want to make a comment during the public and interested parties feedback period.

For questions contact Cerynthia Murphy, Qualification Analyst at (503) 373-1816 or by email at Cerynthia.Murphy@dhsoha.state.or.us

Schedules are subject to change. 9/29/2021

Birthing Center Rules Advisory Committee Update

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August 3, 2020

July 21, 2021

August 24, 2021

September 13, 2021

October 18, 2021

Next Meeting: November 29, 2021

Meeting reports and materials available upon request from the Oregon Health Authority

Public/ Interest Parties Feedback

Executive Session

~

Pursuant to ORS 192.660(2)(f) and ORS 676.595 for the purpose of considering information exempt from public disclosure.

Items for Board Action

Other Board Business

Health Licensing Office
Board of Direct Entry Midwifery
October 21, 2021

****PLEASE PRINT****

Name (First, Last) and Email	Representing	Request to Comment (yes/no)
Silke Ackerson – silkeakerson@gmail.com	Oregon Midwifery Council Two Rivers Midwifery	Yes