HEALTH LICENSING OFFICE
John A. Kitzhaber, M.D., Governor

Oregon Health Authority

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http://www.oregon.gov/OHLA/Pages/index.aspx

WHO: **Health Licensing Office**
Board of Direct Entry Midwifery

WHEN: **February 12, 2015 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/OHLA/DEM/Pages/meetings.aspx for current meeting information.

May the public attend the meeting?
Yes. Members of the public are invited and encouraged to be in attendance at all board/council meetings. All public audience members are asked to sign-in on the attendance roster prior to the meeting.

May the public attend a teleconference meeting?
Yes. Members of the public and licensees may attend a teleconference board meeting at the Health Licensing Office located at 700 Summer St NE, Suite 320, Salem, OR.

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.

REVISED
1:02 pm, Feb 05, 2015

Health Licensing Office
Board of Direct Entry Midwifery

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February 12, 2015 at 9 a.m.
700 Summer St. NE, Suite 320
Salem, Oregon

1. Call to Order

2. Approval of Agenda

3. Executive Session – Pursuant to ORS 192.660(2)(f) for the purpose of considering information or records exempt from public inspection. (Legal Advice)

4. Items for Board Action

- Approval of Agenda
- Approval of Minutes for December 12, 2014
- Approve Proposed Administrative Rules
- Review Continuing Education Courses for Approval – The Matrona

Working Lunch

5. Reports

- Director Report
  -Update on Fee Review
  -Discussion Regarding Disciplinary Sanctions
- Licensing and Fiscal Statistical Reports
- Policy Report
  -Oregon Patient Safety Commission - Early Discussion Resolution
  -Oregon Health Authority Information
    -HERC, Evidence-based Guidelines Subcommittee – Home Birth
    -Division of Medical Assistance Program - Enrollment CCO/MCO
    -Public Health Division – Patient Choice & Notification
    -Public Health Division – Center for Health Statistics
    -Office of Equity & Inclusion – Cultural Competency Curriculum Approval Committee
- Regulatory Report

6. Public/Interest Parties Feedback

- Jesica Dolin, Communications Coordinator Oregon Midwifery Council – written comment

7. Executive Session – Pursuant to ORS 192.660(2)(f) for the purpose of considering information or records exempt from public inspection. (Investigation Files)

8. Regulatory Items for Board Action

9. Other Board Business

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

Executive Session
ORS 192.660(2)(f)
Legal Advice

Items for Board Action

Approval of Agenda

Approval of Minutes

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December 12, 2014

Health Licensing Office
Board of Direct Entry Midwifery

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December 11, 2014
700 Summer Street NE, Suite 320
Salem, Oregon

MINUTES

MEMBERS PRESENT
Colleen Forbes, chair
James di Properzio, vice-chair
Sarah Taylor
Wendy Smith
Kelli McIntosh
Stephanie Elliott
Lenore Charles

STAFF PRESENT
Holly Mercer, Director
Joanna Tucker Davis, assistant attorney general
Sylvie Donaldson, fiscal services and licensing manager
Bob Bothwell, regulatory operations manager
Nathan Goldberg, investigator/inspector
Trampus Schuck, investigator/inspector
Samie Patnode, policy analyst
Amanda Perkins, executive support specialist
Maria Gutierrez, board specialist

MEMBERS ABSENT
None

GUESTS PRESENT
Tracy Lawson-Allen
Nichole Reding

Call to Order

Colleen Forbes called the meeting of the Board of Direct Entry Midwifery (board) to order at approximately 9:48 am. Roll was called.

Holly Mercer, Director, made the following revisions to the agenda:
- Move executive session down in order on the agenda in order to allow for Joanna Tucker Davis, assistant attorney general to arrive.
- Begin addressing items for board action first on the agenda
- Postpone approval of administrative rule schedule for GBS protocols until after receiving legal advice during executive session.

MOTION:
Lenore Charles made a motion with a second by James di Properzio to approve the agenda as amended. Motion passed unanimously.

Administrative Rules

Samie Patnode, policy analyst, reported that the board reviewed and approved proposed administrative rules for filing in the November 1, 2014 Oregon Bulletin. Public comment closed on November 28. The following is a detailed list of amendments being proposed as permanent administrative rules:

- Applicant to be certified professional midwife through the North American Registry of Midwives (NARM)
- Move 40 hour educational requirements for purchasing and administering legend drugs and devices from application requirements to renewal requirements
- Add an additional 5 hours to the standard continuing education requirements and allow licensed direct entry midwives (LDMs) to obtain continuing education hours from online courses
- No changes would be added to the 8.5 LDD renewal program required two years after the initial LDD program
- Exempt traditional midwives from performing direct entry midwifery services. Information required by statute must be disclosed to each patient on a form prescribed by the board

Patnode stated that a hearing was held and written comments were received. Members of the board reviewed comments received including comments from Holly Scholles. Members requested that HLO look into a dormant status for licenses, for LDM who may want to take time away from the practice of midwifery up to three-years. Mercer stated that potential fee changes would be discussed during the Fiscal and Licensing Statistical reports.

Members requested that in regards to moving the 40 hour educational requirements for purchasing and administering legend drugs and devices from application requirements to renewal require within rule the LDM disclose requirements that an LDM must disclose whether they have obtained the 40 hours of LDD training to a client prior to providing services.

Wendy Smith arrived at approximately 10:13 a.m.

MOTION:

Lenore Charles made a motion with a second by Kelli McIntosh to approve the permanent administrative rules as amended. Motion passed unanimously.

Disclosure Statement for Traditional Midwives

Patnode and members of the board reviewed the draft disclosure statement for traditional midwives.

MOTION:

Wendy Smith made a motion with a second by Stephanie Elliot to approve the disclosure statement. Motion passed unanimously.

Temporary Administrative Rule

Patnode explained that based on discussion and in the interest of consumer safety, a temporary rule could be filed to require that an LDM disclose to their client if they have not obtained the 40 hours of education for purchasing and administering legend drugs and devices prior to providing services.

MOTION:

James di Properzio made a motion with a second by Stephanie Elliott to approve the filing of temporary

administrative rules. Motion passed unanimously.

It was noted that HLO will conduct outreach regarding administrative rule changes outlined.

Executive Session

- The Board of Direct Entry Midwifery entered executive session pursuant to ORS 192.660(2)(f) at 10:32 a.m. on December 11, 2014, for the purpose of considering information or records exempt from public inspection. Records to be considered related to legal advice.
- Executive session concluded and the board reconvened regular session at 10:39 a.m. It was noted that no decisions were made and no votes were made in executive session.

Approval of Minutes

MOTION:

James di Properzio made a motion with a second by Kelli McIntosh to approve the minutes for October 2, 2014. Motion passed unanimously.

Approve Supervision Checklist

Patnode reported that HLO has worked with several past and current board members to create a supervision checklist which can be used when an individual is required to be supervised as part of disciplinary action. Initial drafts were reviewed and revised during the August 14, 2014 and October 2, 2014 meetings. Members reviewed the final draft of supervision guidelines presented.

MOTION:

James di Properzio made a motion with a second by Lenore Charles to approve the use of supervision guidelines. Motion passed unanimously.

Guest Speaker-Nichole Reding, Birthingway College Representative-GBS Education

Samie Patnode, policy analyst and Cerynthia Kingsley, qualifications analyst, provided draft LDD curriculum for pharmacology (GBS) to Birthingway College asking for review and input. Nichole Reding presented recommendations including:

- Clarify language around this being in initial education
- Remove pieces that are redundant or not applicable
- Address and be very clear on site selection encompassing risks and benefits of alternative sites
- Significant additional training around the antibiotics themselves

Board members reviewed and discussed this information and risk factor based protocol vs screening based protocol. GBS protocols and education requirements were considered. Mercer asked members of the board if they want to begin approaching review of risk factors during the next rulemaking. Discussion on this topic was postponed.

Review and Approve Continuing Education Courses Provided by The Matrona

Mercer explained that Larry Peck, continuing education credit qualification specialist, provided The Matrona the application criteria for pre-approval of a CE course which outlined that the provider must:

- Be accredited by a federally recognized accrediting agency;
- Be approved by an agency within the Oregon Higher Education Coordination Commission;
- Be an organization offering continuing medical education, including Accreditation Council for

Continuing Medical Education; or
- Must submit justification and be approved by the Board to offer CE's as a professional organization, association, hospital, or health care clinic.

Members decided to postpone discussion and decision making regarding this topic until the next board meeting in order to invite Larry Peck to present related information.

Patnode asked members to approve moving forward with permanent administrative rules and to review the potential of implementing a dormant licensure status and possible fee changes.

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

Director Report
Mercer reported on the following:
- Update on transition to Oregon Health Authority (OHA) and staffing
- Fee reduction process and planning
- Legislative process and update

Licensing and Fiscal Statistical Reports
Sylvie Donaldson, fiscal services and licensing manager, presented an overview of statistics related to the board. Statistics included licensing statistics, license volumes and active license trends.

The statement of cash flow for the period 7/01/13 – 12/09/14 was reviewed and the statement of cash flow for the period 07/01/13-06/30/15 was also reviewed.

Policy Report
Patnode reported on the following:
- OHA Health Evidence Review Commission/Homebirth
- OHA Division of Medical Assistance Program/High Risk Criteria
- OHA Division of Medical Assistance Program/OHP Benefit for Entire Pregnancy
- OHA Public Health/Patient Choice
- OHA Public Health, Center for Health Statistics/Registered Midwives Outreach Letter

This information was reviewed and discussed. Members of the board recommended postponing addressing absolute and non-absolute risk during this rulemaking period. Members would like to look into "well woman care," and whether this is within the scope of practice for licensed direct entry midwives.

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

2009-2011 Biennium Follow Up
Between July 1, 2009 and June 30, 2011, 41 complaints were received. Of the 41 complaints 7 remain open. A summary of allegations received by type of complainant was provided as stated below.

Mandatory Reporter	Client	Other
22	16	3

2011-2013 Biennium
Between July 1, 2011 and June 30, 2013, 28 complaints were received. Of the 28 complaints 12 remain open. A summary of allegations received by type of complainant was provided as stated below.

Mandatory Reporter	Client	Other
14	9	5

2013-2015 Biennium
Between July 1, 2013 and October 31, 2014, 10 complaints were received. Of the 10 complaints 7 remain open. A summary of allegations received by type of complainant was provided as stated below.

Mandatory Reporter	Client	Other
9	0	1

Members asked for clarification regarding what type of notification is sent to the person subject to investigation as to the status of their case in the investigative process.

Public Comment
No public comment was received.

Executive Session
- The Board of Direct Entry Midwifery entered executive session pursuant to ORS 192.660(2)(f) at 12:51 p.m. on December 11, 2014, for the purpose of considering information or records exempt from public inspection. Records to be considered related to investigation files.
- James di Properzio exited the meeting at approximately 1:40 p.m.
- Executive session concluded and the board reconvened regular session at 3:27 p.m. It was noted that no decisions were made and no votes were made in executive session.

Mercer and members of the board outlined the following recommendations:
In regards to investigation file 10-5969
- A notice of revocation be issued.

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

In regards to investigation file 11-6546
- A notice be issued for a two year suspension, followed by one year of supervision by a board approved supervisor under board approved supervisor guidelines.

MOTION:
Kelli McIntosh made a motion, with a second by Stephanie Elliott. Motion passed unanimously.

In regards to investigation file 12-6854

- A notice of one year supervised practice by a board approved supervisor under board approved supervisor guidelines, which may be extended if 10 births are not accomplished within the one year period. The supervised practice will continue until the completion of 10 births. Licensee must provide documentation of successful completion of a course in risk management and a course in charting and documentation.

MOTION:
Lenore Charles made a motion, with a second by Wendy Smith. Motion passed unanimously.

Mercer explained the process of contracting with subject matter experts who assist HLO and the board during the investigative process. Contract rates for subject matter experts were recently increased from $50 an hour to $65 an hour.

The meeting adjourned at approximately 3:32 p.m.

Minutes prepared by: Amanda Perkins, board specialist

Approve Proposed Administrative Rules

Issue Statement

HEALTH LICENSING OFFICE

BACKGROUND:

During the 2013 Legislative Session House Bill 2997 added antibiotics for Group B Streptococcal prophylaxis to the legend drugs for licensed direct entry midwives to purchase and administer. Create administrative rules regarding the purchase and administration of antibiotics for Group B Streptococcal antibiotic prophylaxis for maternal use.

During the December 2014 board meeting Nicole Reding, Academic Coordinator for Birthingway College of Midwifery, provided suggestions and explanation regarding the number of hours for adding antibiotic GBS prophylaxis to the initial legend drugs and devices program as follows:

- Increase hours from 40 to 50
- Add two hours to Pharmacology
- Add eight hours to IV Therapy

A temporary rule was filed to require each licensed direct entry midwife disclose to each patient whether or not they have received the initial legend drugs and devices training. The rule also requires the disclosure is documented within the patient records of care. The proposed rules would make the temporary rule permanent.

ISSUE:

Review draft administrative rules for publication in the Secretary of State (SOS) Oregon Bulletin, April 2015 edition. Public comment will be heard from April 1 to April 28. A public rule hearing will be held on April 28 at 9 am at the Health Licensing Office. The board will review and consider all public comments received and the hearing officer report at the June 11, 2015 board meeting.

RECOMMENDATION:

Approve proposed administrative rules for filing with the SOS.

ADMINISTRATIVE RULE SCHEDULE

HEALTH LICENSING OFFICE
BOARD OF DIRECT ENTRY MIDWIFERY

Date	Action	Time
December 11, 2014	Approve rulemaking schedule	9 a.m.
February 12, 2015	Approve proposed rules	9 a.m.
April 1, 2015	Notice of proposed rules in Oregon Bulletin	
April 28, 2015	Public rule hearing	
April 28, 2015	Last day for public comment	9 a.m.
June 11, 2015	Board meeting review public comment, hearing officer report and adopt permanent rules	9 a.m.
July 1, 2015	Effective date of permanent rule	

The purpose of this rulemaking is to review current legend drugs and devices education and training and new provisions for prophylaxis Group B Streptococcal antibiotics.

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 athttp://www.oregon.gov/OHLA/DEM/pages/index.aspx

HEALTH LICENSING OFFICE

BOARD OF DIRECT ENTRY MIDWIFERY

DIVISION 15

GENERAL ADMINISTRATION

332-015-0030

Application Requirements Direct Entry Midwifery License

An individual applying for licensure to practice direct entry midwifery must:

(1) Meet the requirements of OAR 331 division 30.

(2) Submit a completed application form prescribed by the agency, which must contain the information listed in OAR 331-030-0000 and be accompanied by payment of the required application and license fees.

(3) Submit current certification in cardiopulmonary resuscitation for adults, neonates and infants.

(4) Submit a written plan for emergency transport for mother or newborn pursuant to OAR 332-025-0020.

(5) Submit satisfactory evidence of having current CPM credential from NARM; and

(6) Pursuant to ORS 687.420, participation as an assistant at 25 deliveries, 25 deliveries for which the applicant was the primary birth attendant, participation in 100 prenatal care visits, 25 newborn examinations, and 40 postnatal examinations. 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 one postpartum exam. 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.

(7) If there is more than one birth attendant present at the same birth, the birth attendants must designate which birth attendant is primary.

(8) If the applicant received the ~~Initial~~ **initial** Legend Drugs and Devices Training within 12 months of applying for licensure the applicant must submit proof of receiving the training on a form prescribed by the agency.

(9) If the applicant has not received the initial Legend Drugs and Devices Training at the time of application this information must be disclosed to each patient on the patient disclosure form required under OAR 332-025-0020.

Stat. Auth.: ORS 687.420 & 687.485
Stats. Implemented: ORS 687.420 & 687.485
Hist.: DEM 1-1994, f. & cert. ef. 6-15-94; DEM 1-1998, f. 2-27-98, cert. ef. 3-1-98; 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 4-2010, f. 12-30-10, cert. ef. 1-1-11

HEALTH LICENSING OFFICE,

BOARD OF DIRECT ENTRY MIDWIFERY

DIVISION 20

LICENSURE

332-020-0010

Continuing Education

(1) Standard Continuing Education Renewal Requirements: To maintain licensure an LDM must complete 35 clock hours of continuing education related to services listed in ORS 687.405, cultural competency, patient charting, ethics, communication, or professional development every two years from the date of initial licensure and every two years thereafter.

(2) Legend Drugs and Devices Initial Continuing Education: Upon first renewal or to purchase and administer legend drugs and devices an LDM must successfully complete the 40 clock hours of instruction in an approved legend drugs and devices program approved by the Board. The program is composed of theory, hands-on practice, and skills testing for competency which must include the following:

(a) Eight clock hours in Pharmacology covering drugs listed in ORS 687.493, OAR 332-026-0010 and 332-026-0020;

(b) Four clock hours of administration of medications through injection;

(c) Four clock hours in advanced treatment of shock;

(d) 10 clock hours in intravenous therapy;

(e) Four clock hours in neonatal resuscitation; and

(f) 10 clock hours in suturing.

(3) Legend Drugs and Devices Continuing Education Renewal Requirements: To maintain licensure an LDM must complete eight and a half clock hours of legend drugs and devices (LDD) continuing education, every two-years and attest on renewal application. The LDD continuing education must include components listed under subsection ~~(1)~~ **(2)** of this rule with the exception of neonatal resuscitation which is required for annual renewal. Components must include the following:

(a) Two hours in pharmacology;

(b) One half hour in administration of medications through injection;

(c) One hour in advanced treatment of shock;

(d) Three hours in intravenous therapy; and

(e) Three hours in suturing.

(4) Individuals licensed after January 1, 2016 must successfully complete the Initial LDD Program consisting of 50 clock hours of instruction in the approved curriculum prior to purchasing or administering LDD listed in division 26 of these rules or by the date of first renewal following initial licensing as an LDM.

(5) The initial LDD program is composed of theory, hands-on practice, and skills testing for competency which must include the following:

(a) 10 clock hours in Pharmacology covering drugs listed in ORS 687.493, OAR 332-026-0010 and 332-026-0020 including Group B Streptococcal antibiotics prophylaxis;

(b) Four clock hours of administration of medications through injection;

(c) Four clock hours in advanced treatment of shock;

(d) 18 clock hours in intravenous therapy;

(e) Four clock hours in neonatal resuscitation; and

(f) 10 clock hours in suturing.

(6) Individuals licensed before January 1, 2016 must successfully complete the following:

(a) Antibiotic Group B Streptococcal (GBS) training consisting of 10 hours of instruction in the approved curriculum prior to purchasing or administering GBS antibiotic prophylaxis or by the date of first renewal in 2016; and

(b) Individuals licensed before January 1, 2016 must still complete the requirements in subsection (1), (2) and (3) of this rule, if applicable.

~~(4)~~ **(7)** In accordance with ORS 687.425 a licensee who has attended fewer than five births in the previous year is required to take an additional ten hours of continuing education in subjects listed in subsection (1)~~(a)(A)~~ of this rule during the next annual renewal cycle.

~~(5)~~ **(8)** Continuing Education listed in ~~subsection (1) or (3)~~ may be obtained through online courses, attendance at lectures, sessions, courses, workshops, symposiums seminars or other presentations offered by:

(a) Institutions or programs accredited by a federally recognized accrediting agency;

(b) Institutions or programs approved by an agency within the Oregon Higher Education Coordinating Commission;

(c) An organization offering continuing medical education opportunities, including but not limited to, Accreditation Council for Continuing Medical Education, MEAC accredited or pre-accredited schools and the Oregon Midwifery Council.

(d) Any additional board approved professional organization, or association, hospital, or health care clinic offering continuing education related to subject matter listed **above** ~~in (1) or (2) of this rule~~.

~~(6)~~ **(9)** Continuing education relating to subject matter listed in subsection (1) of this rule may also be obtained through research, authorship or teaching, provided that no more than half the required hours be in research, authorship or teaching.

~~(7)~~ **(10)** Up to nine clock hours of continuing education relating to subject matter listed in subsection (1) of this rule may be completed through self-study. Documentation substantiating the completion of continuing education through self-study must be submitted on forms provided by the agency and must include the following:

(a) Name of sponsor or source, type of study, description of content, date of completion, and duration in hours in accordance with subsection (8) of this rule;

(b) Name of approved correspondence courses or national home study issues;

(c) Name of publications, textbooks, printed material or audiocassette's, including date of publication, publisher, and ISBN identifier; and

(d) Name of films, videos, or slides, including date of production, name of sponsor or producer and catalog number.

~~(8)~~ **(11)** Obtaining and maintaining proof of participation in continuing education is the responsibility of the licensee. The licensee must ensure that adequate proof of attainment of required continuing education is available for audit or investigation or when otherwise requested by the agency. Adequate proof of participation is listed under OAR 332-020-0015(3).

~~(9)~~ **(12)** Documentation of participation in continuing education requirements must be maintained for a period of two years following renewal, and must be available to the agency upon request.

~~(10)~~ **(13)** Hours of continuing education that are obtained in excess of the minimum requirements listed in this rule will not be carried forward as credit for the subsequent license renewal reporting cycle.

~~(11)~~ **(14)** For the purpose of this rule continuing education must include periods of continuous instruction and education, not to include breaks, rest periods, travel registration or meals.

~~(12)~~ **(15)** A copy of Board-approved curriculum objectives for LDD program is available at the Health Licensing Office or on the office website at http://www.oregon.gov/ohla/Pages/index.aspx. Payment of administrative fees may be required. Refer to OAR 331-010-0030 for applicable public record request fees.

Stat. Auth.: ORS 676.615, 687.425 & 687.485
Stats. Implemented: ORS 676.615, 687.425 & 687.485
Hist.: DEM 1-1993(Temp), f. & cert. ef. 12-22-93; DEM 1-1994, f. & cert. ef. 6-15-94; DEM 1-2001(Temp), f. & cert. ef. 10-1-01 thru 3-29-02; 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 2-2008(Temp), f. 9-15-08 cert. ef. 10-1-08 thru 3-30-09; DEM 1-2009, f. 3-31-09, cert. ef. 4-1-09; DEM 5-2010, f. 12-30-10, cert. ef. 1-1-11; DEM 1-2013(Temp), f. 7-10-13, cert. ef. 7-12-13 thru 1-8-14; DEM 2-2013, f. 12-30-13, cert. ef. 1-1-14; DEM 2-2014, f. 12-31-14, cert. ef. 1-1-15

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; ~~and~~

(j) Whether the licensee has obtained the 40 hours of initial Legend Drugs and Devices Training required under OAR 332-020-0010; and

~~(j)~~ **(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

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**, including information regarding completion of the 40 hours of initial Legend Drugs and Devices Training,** has been received by the mother under OAR 332-025-0020.

(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

HEALTH LICENSING OFFICE,

BOARD OF DIRECT ENTRY MIDWIFERY

DIVISION 26

LEGEND DRUGS AND DEVICES

332-026-0000

Access to and Administration of Legend Drugs and Devices

(1) An LDM is prohibited from purchasing or administering legend drugs and devices, including Group B Streptococcal Antibiotics, until the continuing education listed in OAR 332-020-0010 has been completed and documentation submitted and approved by the office.

(2) Pursuant to ORS 687.493, an LDM who satisfactorily completes the continuing education OAR 332-020-0010 is authorized access to and administration of specific legend drugs and devices listed in OAR 332-026-0010, 332-026-0020, 332-026-0030.

(3) An LDM must comply with all local, state and federal laws and regulations regarding the administration, distribution, storage, transportation and disposal of approved legend drugs and devices listed in OAR 332-026-0010, 332-026-0020, 332-026-0030.

(4) Approved legend drugs must be inventoried and securely stored by the LDM at all times the product is not in use, including samples or any remaining portion of a drug.

(5) Records regarding approved legend drugs and devices must be maintained for a period of three years. Records must be kept on the business premises and available for inspection upon request by the Health Licensing Office. Upon request by the board or office, an LDM must provide a copy of records. Records must include, but are not limited, to the following:

(a) Name of drug, amount received, date of receipt, and drug expiration date;

(b) Name of drug and to whom it was administered; date and amount of drug administered to client;

(c) Name of drug, date and place or means of disposal.

(4) Expired, deteriorated or unused legend drugs must be disposed of in a manner that protects the licensee, client and others who may come into contact with the material during disposal.

~~Pursuant to ORS 687.493, an LDM who satisfactorily completes the prescribed education outlined in OAR 332-015-0070 is authorized access to and administration of specific legend drugs and devices listed in OAR 332-026-0010, 332-026-0020, 332-026-0030. The following requirements must be adhered to:~~

~~(1) Licensees must comply with all local, state and federal laws and regulations regarding the administration, distribution, storage, transportation and disposal of approved legend drugs and devices listed in OAR 332-026-0010, 332-026-0020, 332-026-0030.~~

~~(2) Approved legend drugs must be inventoried and securely stored by the LDM at all times the product is not in use, including samples or any remaining portion of a drug.~~

~~(3) Records regarding approved legend drugs and devices must be maintained for a period of three years. Records must be kept on the business premises and available for inspection upon request by the Oregon Health Licensing Agency Enforcement Officers. Upon request by the board or agency, an LDM must provide a copy of records. Records must include, but are not limited, to the following:~~

~~(a) Name of drug, amount received, date of receipt, and drug expiration date;~~

~~(b) Name of drug and to whom it was administered; date and amount of drug administered to client;~~

~~(c) Name of drug, date and place or means of disposal.~~

~~(4) Expired, deteriorated or unused legend drugs must be disposed of in a manner that protects the licensee, client and others who may come into contact with the material during disposal.~~

Stat. Auth.: ORS 676.605, 676.615, 687.485, 687.493
Stats. Implemented: ORS 676.605, 676.615, 687.485, 687.493
Hist.: DEM 1-2001(Temp), f. & cert. ef. 10-1-01 thru 3-29-02; 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; Renumbered from 332-025-0030 by DEM 5-2011, f. & cert. ef. 9-26-11

332-026-0010

Approved Legend Drugs For Maternal Use

Licensees may administer the following legend drugs as approved by the board for maternal use:

(1) Anti-Hemorrhagics for use by intramuscular injection includes:

(a) Synthetic Oxytocin (Pitocin, Syntocin and generic);

(b) Methylergonovine (Methergine);

(c) Ergonovine (Ergotrate); or

(2) Anti-Hemorrhagics by intravenous infusion is limited to Synthetic Oxytocin (Pitocin, Syntocin, and generic).

(3) Anti-Hemorrhagics for oral administration is limited to:

(a) Methylergonovine (Methergine);

(b) Misoprostol (Cytotec).

(4) Anti-Hemorrhagics for rectal administration is limited to Misoprostol (Cytotec).

(5) Resuscitation is limited to medical oxygen and intravenous fluid replacement.

(6) Intravenous fluid replacement includes:

(a) Lactated Ringers Solution;

(b) 0.9% Saline Solution;

(c) D5LR (5% Dextrose in Lactated Ringers); or

(d) D5W (5% Dextrose in water).

(7) Anaphylactic treatment by subcutaneous injection is limited to Epinephrine.

(8) Local anesthetic includes:

(a) Lidocaine HCl (1% and 2%) (Xylocaine and generic);

(b) Topical anesthetic;

(c) Procaine HCl (Novocain, benzocaine, cetacane and generic); and

(d) Sterile water papules.

(9) Rhesus Sensitivity Prophylaxis is limited to Rho(d) Immune Globulin (RhoGAM, Gamulin Rh, Bay Rho-D and others).

(10) Tissue adhesive (Dermabond or generic).

(11) GBS antibiotic prophylaxis is limited to the following:

(a) Penicillin;

(b) Ampicillin;

(c) Cefazolin; or

(d) Clindamycin.

Stat. Auth.: ORS 676.605, 676.615, 687.485 & 687.493
Stats. Implemented: ORS 676.605, 676.615, 687.485 & 687.493
Hist.: DEM 1-2001(Temp), f. & cert. ef. 10-1-01 thru 3-29-02; 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; Renumbered from 332-025-0040 by DEM 5-2011, f. & cert. ef. 9-26-11

LD&D Curriculum for Pharmacology (GBS)

Objectives	Dosage Guidelines	Instructors	Resources
Provide clear informed choice regarding the risks and benefits of IV antibiotics in labor for Newborn GBS disease prevention Define and explain drugs specifically related to Perinatal Group B Streptococcal Disease prophylaxis to include: • Patient Assessment • Action and effect • Adverse reactions Explain placental transfer of medication to the fetus Explain how an antibiotic moves through the body: ♦ Absorption rate ♦ Metabolism ♦ Excretion ♦ Mechanism of pharmacological action ♦ Indications ♦ Therapeutic effects ♦ Side effects/ adverse reactions ♦ Contraindications ♦ Incompatibilities/drug interactions Administration including: ♦ Dosage ♦ Dosage form and packaging ♦ Onset of action ♦ Peak effect ♦ Duration of action/half-life ♦ Storage, transport and security ♦ Disposal Chart the use of authorized antibiotics	Penicillin G 5million units I.V. with initial dose, 2.5 million units every (4) four hours until delivery. Ampicillin, 2g I.V. with initial dose, 1g I.V. every (4) four hours until delivery. Cefazolin 2g I.V. with initial dose, 1g I.V. every (8) eight hours until delivery. Clindamycin 900mg. I.V. every (8) eight hours until delivery.	♦ Licensed Pharmacist (not limited to Oregon Licensure) ♦ Licensed Midwife ♦ Licensed RN or CNM ♦ Licensed Physician - MD, DO, ND ♦ Physician Assistant	Current Edition of the following: ♦ Pharmacology for Midwives by Jane Poznar, Rph (Not sure if there is a current edition of this one) ♦ Physicians Desk Reference ♦ Drug Topics; Facts and Comparisons ♦ CDC Prevention of Perinatal Group B Streptococcal Disease ♦ Ontario Midwives. *Clinical Practice Guideline No. 11*. Group B Streptococcus: Prevention and Management in Labour.

Reasons for using I.V. therapy for Perinatal Group B Streptococcal Disease prophylaxis List necessary equipment and supplies for administration of antibiotic prophylaxis in labor List and explain appropriate use of I.V. solutions with antibiotics Explain and describe all appropriate administration sites for IV antibiotics in labor, including risks and benefits of each Explain in detail the appropriate procedure for administration of antibiotics with I.V. fluids Describe appropriate flow rates for I.V. administration of antibiotics. Demonstrate, on mannequin, appropriate steps for administering I.V. Antibiotics in labor Demonstrate, on live model, appropriate steps for preparing and maintaining a saline lock (for antibiotic prophylaxis in labor), including: • where to place • how to place • how to maintain, including flushing • how to disconnect Demonstrate, on live model, correct administration and discontinuation of four I.V.s for antibiotic prophylaxis in labor in at least two different appropriate sites	♦ IV Fluid Types • 0.9% Saline Solution • Lactated Ringers Solution • D5LR • D5W and antibiotics as listed under pharmacology section	♦ Licensed Midwife ♦ Licensed RN, CNM ♦ Licensed Physician - MD, DO, ND ♦ Certified Paramedic ♦ Physician Assistant	Current Editions of the following: ♦ Practical Skills Guide for Midwifery, Pam Weaver and Sharon K. Evans, ♦ Advanced Emergency Care by Shirley Jones, Al Weigel, Roger White, Norman McSwain and Marty Breiter. Published by Lippincott Williams and Wilkins. ♦ Holistic Midwifery II: Care During Labor and Birth by Anne Frye – current edition ♦ CDC 2010 Prevention of Perinatal Group B Streptococcal Disease ♦ Ontario Midwives. *Clinical Practice Guideline No. 11*. Group B Streptococcus: Prevention and Management in Labour.

Review and Approve Continuing Education Courses

~

The Matrona

ISSUE STATEMENT

HEALTH LICENSING OFFICE
BOARD OF DIRECT ENTRY MIDWIFERY

BACKGROUND AND DISCUSSION:

On Oct. 14, 2014, the Office provided "The Matrona" (school of midwifery), the application criteria for pre-approval of a CE course. Which included criteria outlined in OAR 332-020-0010, that the provider must: 1) Be accredited by a federally recognized accrediting agency; 2) Be approved by an agency within the Oregon Higher Education Coordination Commission; 3) Be an organization offering continuing medical education, including Accreditation Council for Continuing Medical Education; or 4) Must submit justification and be approved by the Board to offer CE's as a professional organization, association, hospital, or health care clinic.

ISSUE:

The Matrona website, www.thematrona.com, states the following:

"The Matrona is not accredited by any governing body, including the United States Dept. of Education or the Midwifery Education Accreditation Council (MEAC). This is a conscious choice on the part of The Matrona, feeling that it allows a much more dynamic approach to what we can teach, not being limited and controlled by an outside organization. However, we then cannot receive financial aid from the United States Government."

On Oct. 15, 2014, The Matrona submitted justification for board approval to offer CE to Oregon LDM's, and documentation to request pre-approval of a CE course offered on Nov. 7th – 9th, 2014, titled "Quantum Birthing Weekend".

The Matrona did not provide any supporting documentation with their request that reflects any accreditation, approval or credentialing from the agencies or organizations adopted in OAR 332-020-0010, and therefore must rely on board approval to provide CE to Oregon LDM's.

BOARD ACTION:

Review justification documentation submitted and determine the following:

1) Approve or deny The Matrona as a CE provider to offer CE courses to Oregon LDM's:
   - ✓ Exhibit A: paragraph #1 "CE "Application for LDM by HLO".
   - ✓ Attachment 1: *Categories of Knowledge taught at the Matrona.*
   - ✓ Attachment 4: *Instructor Resume*

2) Approve or deny of The Matrona CE course "Quantum Birthing Weekend"
   - ✓ Exhibit A: paragraph #4 "Course Content"
   - ✓ Attachment 2: *HLO CE Pre-approval Request form*
   - ✓ Attachment 3: *Course agenda and outline*
   - ✓ Attachment 4: *Instructor Resume*
   - ✓ Attachment 5: *Method of recording or reporting attendance or successful course completion.*

3) If approval is granted, determine:
   - ✓ Effective date of approval and should the approval be retroactive back to the Oct. 15, 2014, receipt date of the pre-approval request for the course "Quantum Birthing Weekend" offered on November 7th – 9th.

Exhibit A

October 14, 14

RE: CE Application for LDM by HLO

To Whom It May Concern:

This letter is to accompany the attached requested information for application to obtain CE approval by HLO for LDM's in Oregon.

1. **Justification as a professional organization, association, hospital, or health care clinic offering continuing education for board approval to provide CE to Oregon LDM's:**

   The Matrona has been an established Midwifery School since its founding in 2001. We offer a Midwifery program that meets and exceeds the Midwifery Core Competencies of MANA for Midwifery care in the United States. (Also see Instructor Resume, Attachment 5)

   Attachment 1: Categories of Knowledge taught at the Matrona in our Midwifery program

2. **Completed HLO CE approval request form**

   Attachment 2: HLO Approval Form

3. **Course Agenda and Course Outline**

   Attachment 3

4. **Course Content; Identify the specific relationship between the course training and the responsibility of the LDM:**

   The Matrona has been teaching Quantum Birthing Weekends to Midwives for the past 5 years. Currently we are certified to offer CEU's to Licensed Midwives in California. The curriculum (as you will see in the Agenda/Outline) is relevant to Midwives. It addresses information on women's health (Friday and Saturday PM Sessions), neonatal, fetal or midwifery knowledge or care (Sunday AM & PM Sessions), ethics,

communication, or professional development (Friday and Saturday AM Sessions).

5. **Instructor Resume**

   Attachment 4

6. **Method of recording or reporting attendance or successful course completion**

   Attachment 5

Thank you for your consideration.

Jaydee Sperry

Administrator
The Matrona
www.thematrona.com
810-358-9515

ATTACHMENT 1

The Tao of Midwifery

And so, the Midwife performs her work by doing nothing,
She teaches without saying a word,
Things arise and she lets them come,
Things leave and she lets them go,
Creating, not possessing,
Working and laying no claim,
And when her work is done, she releases it,
And so it lasts forever.

Categories of knowledge for beginner level entry in Traditional Midwifery:

- Category I -- Subjects, terms, skills and theories with which you have absolute familiarity and beginning level proficiency. This includes topics such as how to recognize and handle a postpartum hemorrhage, how to recognize and resuscitate the asphyxiated newborn, how to nurture the pregnant mom, how to recognize and handle an IUGR baby, how to auscultate and interpret FHTs...
- Category II – Subjects, terms, skills and theories, which are quite familiar to you but which you may need to refresh or research further. This includes Rh sensitization, recognizing and providing homeopathic treatment of hypothyroidism, delivery of twins, remedies for diabetes...
- Category III – Subjects terms, skills and theories for which you have a point of reference but need to research for complete information. These areas of information are used infrequently and, at this point, require a passing knowledge and understanding. This includes the glomerular filtration rate of the kidneys, various medical values for blood work and testing, the names of the muscles in the body…

Category I
Professional Standards, Knowledge and Skills

This category includes subjects and skills with which you have immediate familiarity and proficiency –

- How to nurture and caretake yourself and/or another. This includes active listening skills, the ability to suspend judgment, the ability to respond appropriately in the area of details and in the big picture, the ability to interpret information correctly and a sense of compassion and genuine caring. The ability to nurture implies the ability to feed the spirit and soul, the mind, heart and body of another or yourself.

- A thorough understanding of the Wise Woman Tradition and the ability to use the theories and skills to approach any concern – physical, emotional, mental or spiritual and to see the WWT as a dynamic web of healing potential.
- A working knowledge of the quantum paradigm, the holistic paradigm and the differences between the humanistic and mechanistic paradigms; the ability to practice in the quantum and holistic paradigms.
- A comfortable relationship with the altered state and with the realms of the sacred.
- A basic relationship with the skills and tools of intuition and the ability to incorporate these skills into everyday life and practice.
- An understanding of how to offer time, energy and attention.
- The ability to understand the principles of woundology and the far-reaching consequences of re-creating wounded patterns in our lives and in the birthing continuum.
- An understanding of why and how to create soul-level connections with people.
- An understanding of the difference between ideas and ideologies and the means to articulate this difference.
-
- Recognition of the Caregivers Spiral and how to integrate with the caregiving community, in collaborative behavior without loosing professional autonomy.
- The ability to differentiate between laws and the Standard of Care within communities, and to adequately explain the parameters of informed choice/consent and the right to set self-determination.
- The ability to inform parents of the legal, political and cultural guidelines regarding childbirth in the communities you both live within.

- A working knowledge of homeopathy and the ability to offer beginning-level prescribing for emergencies – not just childbirth-related situations; an understanding of the theory and importance of miasms and their treatment; the importance of constitutional and fundamental treatment of the pregnant mother; the ability to use appropriate beginner-level homeopathy in all walks of life.
- A working knowledge of herbs, especially the specific herbs for the childbearing cycle; an understanding of how herbs are used in the Wise Woman Tradition; an understanding of the various classifications of herbs – nutritive, toning, specific, potentially toxic; an understanding of how to make and use teas and tinctures for beginning-level treatment of everyday ailments.
- The ability to understand and use medical vocabulary eloquently and appropriately, as it applies to anatomy and physiology and specifically the areas of childbearing and well woman care.

<u>Anatomy and Physiology for Midwives including:</u>

- An understanding of the language of anatomy – anatomical positions and directional terms, body cavities and body quadrants.
- An understanding of the meaning and concepts of homeostasis and homeodynamics.

- A knowledge of all the organs of the body, what system they belong to and where they are located.
- A basic knowledge of the endocrine system and the glands of the body – where they are located, what hormones they secrete, what chakra they are associated with and what each hormone is responsible for.
- A basic understanding of the cardiovascular system including the path of blood flow through the heart, basic knowledge of veins and arteries, the components of blood, diagnostic blood tests for the childbearing cycle and the physiology of circulation including blood pressure.
- A basic understanding of the function of the lymphatic system and the major lymphatic organs in the body.
- A basic and simple understanding of the immune system including the basic premise of the immune response and the components of the non-specific immune system.
- A basic understanding of the respiratory system including the anatomy of the respiratory tract; the mechanics of breathing and the principles of oxygen and carbon dioxide transfer.
- A basic understanding of the functions of the digestive system including functional anatomy and the physiology of digestion and absorption.
- An understanding of physical nutrition including the process of metabolism and the essential nutrients – carbohydrates, lipids, proteins, vitamins, minerals and water.
- A basic understanding of the fluid balance of the body, the electrolyte balance in the body and the pH balance in the body. An understanding of acidosis – how to prevent, recognize and correct this concern in mother and/or baby.
- A basic understanding of the urinary system including functional anatomy and the physiology of urine formation and filtration.
- A working knowledge of the female reproductive system including the female anatomy, both internal and external – ovaries, uterus, ducts and yoni; recognition of external genitalia. A working knowledge of female physiology including the ovarian cycle and the menstrual cycle. A working understanding of the basic female hormones – especially estrogen and progesterone, as well as FSH and LH, and their effect on the female cycles.
- A working knowledge of vaginal ecology and STI's including syphilis, gonorrhea, herpes, chlamydia and candida – cause, recognition, prevention and treatment.
- A basic knowledge of the physical changes that occur at puberty, with fertility, and in menopause.
- The study of well-woman care.
- A working knowledge of pregnancy and human development from the anatomy and physiology point of view including fertilization, basic embryonic development, and basic fetal development. This information to be continued in detail in the pregnancy, birth postpartum sections.
- A basic understanding of the male reproductive system including functional anatomy and male physiology.
- An understanding of how physiology informs the functioning of the childbearing continuum.

A thorough knowledge of prenatal care and pregnancy and all its variations including:

- The signs and symptoms of pregnancy.
- How to identify and counsel for any pre-existing conditions that may influence pregnancy.
- Understanding normal uterine and fetal development in each trimester of pregnancy.
- Relevant prenatal testing – what tests are available, what they are for and when they are advised. This includes blood work and urine analysis – hematocrit/hemoglobin testing, a CBC, blood type and Rh testing, Rubella titer, antibody titers for Rh negative moms, STI testing, AIDS testing, genetic screenings and tests, the GCT/OGTT, ultrasound testing, amniocentesis, urinalysis, Group-Beta Srep testing and a BPP for the assessment of fetal well being.
- How to take a client history and begin prenatal record keeping.
- How to determine the EDB, with and without the wheel.
- How to understand and assess the implications of teratogenic exposures during the childbearing continuum.
- How to conduct an initial prenatal visit including mental, emotional and physical assessment. How to continue to thoroughly provide prenatal visits, including accurate note and charting techniques/options.
- How to obtain a clean catch of urine.
- How to check urine with a dipstick and how to interpret results for twelve different findings.
- How to perform a yoni exam including exam of the external genitalia, the cervix, perineum and yoni.
- How to perform pelvimetry.
- How to instruct a woman to do breast massage and examination.
- How to abdominally palpate the uterus, how to evaluate the size and position of the fetus, how to measure fundal height.
- How to recognize a posterior, breech, multiple pregnancy and other variations of position.
- How to assess the volume of amniotic fluid and recognize and care for a mom with poly and/or oligohydramnios.
- How to auscultate FHTs with a fetascope and a doppler.
- How to interpret FHT patterns and act accordingly to any variations of normal.
- How to take blood pressure, temperature and pulses and to assess respirations.
- How to assess for edema, clonus and CVAT and to understand the relevance of these assessments.
- How to assess the well-being of the growing fetus through fetal activity testing, including how to perform in-home version of an NST.
- How to recognize and care for an IUGR baby.
- How to recognize and deal with preterm labor, ectopic pregnancy, placenta previa and an abrupted placenta.

- How to differentiate the cause of prenatal bleeding and how to offer subsequent care.
- How to recognize an impending miscarriage and how to care for the mom who is miscarrying.
- How to recognize and treat discomforts of pregnancy – using the wise woman tradition. Including the use of herbs, homeopathy, acupressure and other natural modalities.
- How to recognize and treat a UTI, pre-eclampsia, anemia, an STI, hypertension and PIH, a molar pregnancy, an ectopic pregnancy, premature rupture of membranes and prolonged rupture of membranes.
- How to recognize, prevent and change a posterior presentation to a more favorable anterior presentation.
- A basic understanding of the version process for breech baby.
- An understanding of gestational diabetes and pre-eclampsia and how to respond and treat in the Quantum paradigm.
- How to check blood type and Rh with an Eldon blood card.
- How to recognize and treat stress in the pregnant family.
- How to create a rite of passage for the pregnant family through childbirth education, a Blessingway and/or other special events for the pregnant family or mother.
- How to help prepare other children or family members for the birth and the new baby.
- How to inspire women to empower themselves and their families.

<u>A thorough understanding of labor and birth, differentiating between Facilitation vs. Management, including:</u>

- The principles of Birth as an Altered State and the mothers need for privacy, warmth, dark, silence and safety, and nourishment both physically and psychologically.
- The understanding of Undisturbed Birth and the ramifications of returning birth to the family.
- A thorough understanding of the Holistic Stages of Labor with the clinical model.
- An understanding of how the cardinal movements of labor correspond to the Holistic Stages of Labor.
- The mechanism of labor and birth – physically and psychically including the Holistic Stages of Labor, the relevance of cervical dilation, the descent, flexion and rotation of the baby and the emotional and physical signs of labor progressing.
- A complete understanding of both stages of 2nd stage of labor (latent and active) and the work of Constance Beynon.
- How to assess contractions, cervical dilation, rupture of membranes, changes in maternal vital signs, rupture of membranes, and meconium staining.
- How to assess and interpret FHT patterns in labor and how to respond to any abnormal or unreassuring patterns.

- How to respond to meconium staining.
- How to assess dilation on the mother's foot and use other non-invasive means to assess the progress of labor.
- How to provide basic comfort measures for the laboring mom.
- How to facilitate a mother who chooses to birth in various positions.
- How to facilitate a mother who chooses waterbirth.
- How to work with and resolve posterior presentation in labor.
- How to recognize, prevent and treat a cervical lip in labor.
- How to manually assist the delivery of the baby including nuchal cord, nuchal arm, shoulder dystocia, unusual presentation, and perineal support.
- How to administer oxygen to the mother in labor and the reasons to do so.
- How to apply the tenets of the Wise Woman Tradition to the unfolding of a sacred birth.
- How to 'do nothing', how to work with the energy, nourish and tone, stimulate and/or sedate, use potent specifics and/or break and enter when necessary.
- How to maintain the scene.
- How to manage your energy when a mother/family chooses something outside of predicted expectations, and how to support them in their choices.
- How to recognize and facilitate an emergency situation in mother and/or baby. Including abnormal bleeding, altered vital signs and non-reassuring FHT's.
- Understand the for transport and the ability to facilitate a smooth, fulfilling and safe transition between birthing sites if necessary.
- An understanding of the medical technologies used in a clinical setting.
- How to use herbs, homeopathics and other natural means to facilitate the course of labor in the most empowering way possible.

<u>A thorough understanding of the postpartum including:</u>

- Immediate postpartum assessment including assessment of placental separation and bleeding.
- Ability to understand the physical, hormonal and pshychological process of placental separationg and subsequent birth of the placenta. Understanding that the placenta expulsion is a 'birth' in and or itself. The ability to allow this process to unfold in an undisturbed way.
- Understand the importance of Matrescence or 'mother making' and how each stage of birth (baby and placenta) and bonding (breastfeeding) completes an aspect of this process.
- Ability to obtain a cord blood sample and understanding the reasons why.
- Ability to facilitate delivery of the placenta including manual removal if necessary.
- Ability to prevent, recognize and control a postpartum hemorrhage including the appropriate use of homeopathics, herbs, bimanual compression and any and all other means at your disposal.
- Ability to assess the placenta and create placenta medicine for the mom.
- Ability to assess perineal lacerations and offer appropriate treatment.
- Ability to help the mom initiate breastfeeding and give the mom relevant information about her breasts, her infant and the process.

- Understanding of the hormones prolactin and oxytocin and their importance in birth and breastfeeding.
- Understanding of uterine involution during the first days of postpartum.
- Ability to provide excellent postpartum care for the next six weeks including aid with afterpains, recognition of a late postpartum hemorrhage, understanding signs and symptoms of infection, recognizing problems with breastfeeding, hemorrhoids, stress, thromboemboletic disease, concerns from loss of sleep and concerns with infant bonding.
- Recognizing signs and symptoms of postpartum depression and offering appropriate treatment and prevention in the Quantum paradigm.
- Ability to assess lacerations according to REEDAT.
- Understanding The Return and why it is inappropriate to handle, manage, or pick up a newborn infant during this stage. Recognizing the physiology that undergirds this process and not disturbing the newborn.
- The ability to understand why the mother should never be disturbed during her Return in the immediate postpartum and the ability to offer undisturbed postpartum care.
- The ability to continue to guard and protect the new family during the time that the vortex is still open.
- The ability to nurture the mom and new family by helping her/them weave their birth experience with integrity and honesty.
- The ability to help families find resources and support during the postpartum.
- The ability to care for a mother with a disappointing outcome...a transport, a C-section or an unhealthy baby.

<u>A thorough understanding of the newborn period including:</u>

- Immediate assessment and care of the newborn at birth.
- Understanding of the cardiac changes that occur during the transition to neonatal life including the temporary structures in the fetal heart.
- Understanding the respiratory changes that occur in the newborn's initiation of breathing
- Ability to assess respiratory and cardiac function in the newborn.
- Ability to administer oxygen after delivery.
- Ability to recognize and manage asphyxia in the newborn including the use of homeopathic, herbs, acupressure and NNR techniques.
- Ability to assess APGAR scores, gestational age, neurological maturity and function, including reflexes.
- Ability to clamp and cut the cord and/or the ability to offer lotus birth. Ability to assess the cord during the postpartum, recognizing signs and symptoms of infection. Ability to prevent and treat infection of the cord.
- Understanding of why the cord is never cut immediately after birth.
- Ability to recognize normal and abnormal breathing patterns in the neonate. Assessment of RDS and signs and symptoms of infection. Ability to recognize and offer appropriate treatment and/or referral or transport for any neonate who is ill or suffers from any concern beyond the usual variations of normal.

- Ability to perform the newborn exam (or assist the parents in doing so), recognizing the characteristics of the normal newborn and document the pregnancy, labor, birth and initial exam of the infant.
- Understanding or typical biotechnical newborn screening and treatment.
- Understanding the reasoning behind eye care prophylaxis, vitamin K administration, circumcision, and immunization. Assisting families in navigating choice concerning these topics.
- Ability to assess breastfeeding in the infant, both at the birth and afterward.
- Ability to offer eye care to the infant. Ability to recognize plugged tear duct and differentiate from infection.
- Understanding of the infants need for temperature regulation, feeding and bonding during the neonatal period. Understanding the parents need for education and information about their newborn and the ability to provide guidance when necessary.
- Ability to use herbs and homeopathics for concerns in the newborn.
- Ability to recognize and treat jaundice in the newborn. Ability to assess the severity of the jaundice and discover the cause.
- Ability to asses continuing neonatal well-being in the areas of growth and development.
- Ability to give supportive information about breast and bottle feeding and supporting a woman's choice.

<u>In the Realms of the Wisdom Arts</u>

- The ability to see and think in the larger dimensions, to ask effective questions and to find the appropriate answers.
- The ability to believe in the unity of all things – including each other.
- The ability to understand that midwifery is about facilitating birth, not about facilitating midwives.
- The ability to resolve conflict through collaborative means.
- The ability to access bravery and commit random and deliberate acts of courage during your life and practice.
- The ability to meet people where they are at, to understand everything on the planet and to actively listen to others.
- The ability to recognize and heal your wounds.
- The ability to understand the concepts of rank and to use power and privilege wisely.
- The ability to be with woman and not need women to be with midwife.
- The ability to grasp the notion of the paradox and to intend to be comfortable at the edge of your comfort zone.
- The ability to respond in a place of neutrality and suspend judgment.
- The understanding of the basic skills of Conflict Resolution and how to implement them.
- The understanding of the tenets of Eldership and how they pertain to midwifery.
- An understanding and appreciation of Sexual Wisdom and Sexuality as a path to the divine.

- An understanding of the Tao of Midwifery in all it's unfolding.
- The ability to trust parents, birth and yourself and to place authority in the appropriate hands. You honestly believe that birth is natural event, a rite of passage rather than a medical event even if medical care is involved in the process. You trust that parents are the true experts about their bodies and their births and that your work as a midwife is to inspire families to create and experience what is welcomed and destined for them.
- You believe that you are a competent, confident, compassionate and caring midwife. You are confident enough to trust birth and parents and return authority to them. You are competent enough to know that when and if others need you, you will be able to provide appropriate and relevant information and function with a level of skill that reflects the wisdom of their judgment in choosing you to serve their needs. You will respond intelligently and effectively. You have the ability to respond with compassion, being totally in the present, suspending prior judgments, putting yourself in the place of the birthing family while remaining always in the big picture. As a caring midwife you serve as the bridge between the sacred and the mundane.

A Midwife's Practice

At The House of La Matrona we envision Midwifery as part of the original model of womancare handed down from the beginning of human time. This model has evolved and changed continuously over the centuries and is currently a vast and ever expanding tapestry of birthing consciousness. Mothers and midwives are the principle weavers. Working in concert, we preserve a model of bringing forth life with dignity and grace. Together we facilitate the creation of family and community on this planet.

As midwives, we do not strive to control birth – or each other.
Rather, we allow birth to evolve freely and gracefully to its natural conclusion.
In doing so, each of us – mother, father, baby and midwife – unfolds as a more whole and perfect human being. Midwifery calls each of us to our highest and best.
In our quest to cultivate ourselves and serve others with love and respect,
we facilitate important rites of passage. As midwives we guard the doors
of birth and death, healing and growth. We empower each other and ourselves
by allowing the process of life to unfold according to and individual divine plan.
At The House of La Matrona we come together to develop our innate spiritual selves.
We experience the rites of passage attendant on becoming a Midwife,
we seek realms of higher learning and we learn to be comfortable and conversant
with the body-mind-spirit continuum.

The privilege to attend women and families in birth requires commitment and dedication to a lifestyle that embraces a desire to pursue the sacred.
A Midwife's practice reflects her experience of what is holy, what is honorable,
what is generous, compassionate, noble and loving.

From her ability to heal herself comes the power to facilitate healing in others.
From self-respect flows respect for others.
From connection with the Ancient Heart of Midwifery, the old and sacred traditions, comes the ability to remember the ways that have served families for centuries.
From authentic spiritual practice and incorporation of the sacred as part of daily life comes her ability to practice midwifery with an appropriate balance of intuition and skills.
From this perspective all else flows.

ATTACHMENT 2

Oregon Health Licensing Agency

700 Summer St. NE, Suite 320
Salem, OR 97301-1287
Phone: (503) 378-8667
Fax: (503) 370-9004
Website: http://www.oregon.gov/ohla
E-mail: ohla.info@state.or.us

REQUEST FOR APPROVAL OF CONTINUING EDUCATION COURSE

IMPORTANT: Attachment of course outline or agenda, course content, resume of speakers or instructors, and method of recording satisfactory course completion is required to process request. To expedite request, please submit this form electronically via email, in Word.doc format, with documentation attached to: ohla.info@state.or.us.

PROFESSIONAL BOARD/COUNCIL FOR WHICH REQUESTED CONTINUING EDUCATION APPLIES:	DATE OF REQUEST:
☐AT ☐BAP ☐COS ☒DEM ☐DT ☐EHRB ☐HAS ☐LD ☐NHAB ☐RTPT ☐SOTB	10/15/2014

BRIEFLY DESCRIBE COURSE RELATIONSHIP TO THE PROFESSIONAL LICENSURE INDICATED ABOVE:
We are an established Midwifery school since the year 2001.

GENERAL HOURS REQUESTED:	ETHICS HOURS REQUESTED (if applicable):	TOTAL CE HOURS REQUESTED:
24		24

COURSE TITLE:
Quantum Birthing Weekend

COURSE DATE(S); OR INDICATE VARIOUS HERE: ☐	TIME(S); OR INDICATE VARIOUS HERE: ☐
November 7th-9th, 2014	9:30-1, 2-5:30

COURSE LOCATION(S); OR INDICATE VARIOUS HERE: ☐
Portland, OR

IS COURSE REPEATED? ☐ YES ☒ NO	IF YES; HOW OFTEN?	END DATE:

CONTINUING EDUCATION METHOD:
☐ MEETING ☒ CLASSROOM ☒ WORKSHOP ☐ SEMINAR ☐ ONLINE ☐ CORRESPONDENCE ☐ OTHER:

SPONSOR/PROVIDER:	WEBSITE ADDRESS:
The Matrona Midwifery School	www.thematrona.com

CONTACT NAME: Jaydee Sperry	EMAIL: jaydeematrona@gmail.com	
ADDRESS(OPTIONAL):	PHONE: 810-358-9515	FAX:

OFFICE USE ONLY

AGENCY APPROVAL NUMBER:

COURSE APPROVED? ☐ YES ☐ NO	APPROVED GENERAL HOURS:	APPROVED ETHICS HOURS:	MAXIMUM APPROVED HOURS:

MULTI DAY/AGENDA COURSE: ☐ YES **(verify course approval documentation at audit)**

IF NO, EXPLAIN WHY REQUEST DENIED:

Ctrl + Click On the Email Address Above to Submit Request: Please Remember to Attach All Required Documentation

ATTACHMENT 3

QUANTUM BIRTHING WEEKEND LOGISTICS

RETURN TO OB

Our next Quantum Birthing Weekend will be
November 7th - 9th in Portland, OR!

For details or to register email Kendra Romer -- romerk@gmail.com

Friday

A Quantum Paradigm and Evolving Models of Care
Trusting Women and Creating Soul-Level Connections
Navigating Ideas and Ideologies in Childbirth

Endocrine System: Hormones as Messengers
Oxytocin and Beyond: Birth as an Altered State
BrainWave Patterns and the Neurological Perspective on Birth

Saturday

The Caregivers Greatest Gift: the Circle of Nurturing
Vulnerability, Woundology and Using our Power Wisely

ATTACHMENT 3

Course Agenda and Course Content

Friday AM November 7, 9:30-1

Session Title__Defining Quantum Midwifery and Evolving Models of Care

Session Length in minutes_____210 min.

1. Speakers Name(s): Whapio Diane Bartlett

2. Behavioral Objectives: Describe what the participants are expected to have learned from this program. Describe what knowledge or skills the learners will be able to demonstrate following the learning experience.

-Demonstrate and teach four different Models of Care in the childbirth continuum: (as first defined by Robbie Davis-Floyd) the Technocratic Model, the Humanistic Model, the Holistic Model, and (now with the instruction of this session) the evolving Quantum Model.
-Demonstrate ways of supporting women with the new knowledge of Soul Level Connections, and the psychological concepts of Ideas and Ideologies in the realms of childbirth

3. Session Content: Statements should support behavioral objectives listed above. List approximate minutes of time spent on each subject area.

-1.5 hours defining Models of Care
-2 hours discussing the concepts of how do we Trust women in our care during the childbirth continuum, and allow them to shape our practice and our care for them, rather than us, as providers, having women conform to our expectations and Ideas and Ideologies

4. Assessment of Learner Outcome:

Pre/Post Test Question	___Oral_____
Written/Oral Exam	_____
Demonstration of Skills	_____
Discussion	_____X_____
Projects	_____

5. Pre and Post Session Test Questions and the Answers that the participant

should have learned that directly relate to behavioral objectives.

1. What are the four Models of Care presented? Technocratic, Humanistic, Holistic and Quantum
2. What is an Ideology? An idea that has become an object of control, rather than an object of discovery and support.
3. What is one of the best ways we (at the Matrona) are suggesting to remain solvent in the realms of ideas and not succumb to ideologies? Create Soul-Level Connections with the people we serve.

6. 5 current references from the past 4 years that you have used to prepare this session (texts and journal articles are acceptable). Be sure to include titles (journal and article where applicable) and publication dates.

Holistic Midwifery Vol. 1 by Anne Frye, CPM, revised edition published in 9/2010
Dance of the Ancient One by Arnold Mindell, published 6/2013
The Heart Mind Matrix by Joseph Chilton Pearce, published 8/2012
Defy Gravity by Caroline Myss, published 1/2011
Primal Health by Michel Odent, published 7/2012

LUNCH 1-2

Friday PM November 7, 2-5:30

Session Title__The Endocrine System, Oxytocin and the Neurological Perspective on Birth

Session Length in minutes_____210 min.

1. Speakers Name(s): Whapio Diane Bartlett

2. Behavioral Objectives: Describe what the participants are expected to have learned from this program. Describe what knowledge or skills the learners will be able to demonstrate following the learning experience.

-Teach Brain Wave Patterns in relation to pregnancy and childbirth
-Demonstrate the adjustments made in the Endocrine System during the childbearing year
-Create a model of labor support techniques that honor the Oxytocin/Endocrine processes that naturally occur during this time

3. Session Content: Statements should support behavioral objectives listed above. List approximate minutes of time spent on each subject area.

-1.5 hours defining the Endocrine System and how it adjusts during the childbearing year
-1 hour defining the effects of Oxytocin on labor, birth and the postpartum period
-1 hour defining brain wave patterns and the neurological perspective of childbirth

4. Assessment of Learner Outcome: Give examples of how learner achievement will be assessed (check all which will apply, including test Q's and A's).

Pre/Post Test Question	___Oral_____
Written/Oral Exam	_____
Demonstration of Skills	_____
Discussion	_____X_____
Projects	_____

5. Three Pre and Post Session Test Questions and the Answers that the participant should have learned that directly relate to behavioral objectives.

1. What are the major Endocrine organs in the body? The Pineal, Pituitary, Thyroid (Parathyroid), Thymus, (Heart), (Mammary), Pancreas, Gonads, and Adrenal glands.

2. What hormones does the Posterior Pituitary gland secrete? Oxytocin and Vasopressin
3. What are the four major brain wave states? Beta, Alpha, Theta and Delta

6. 5 current references from the past 4 years that you have used to prepare this session (texts and journal articles are acceptable). Be sure to include titles (journal and article where applicable) and publication dates.

Holistic Midwifery Vol. 1 by Anne Frye, CPM, revised edition published 9/2010
Anatomy and Physiology for Midwives 3rd Edition by Jane Coad, published 6/2011
Pineal Gland & Third Eye: Proven Methods to Develop Your Higher Self by Dr. Jill Ammon-Wexler, published 1/2014
Childbirth and the Future of Homo Sapiens by Michel Odent, MD published 11/2013
Optimal Care in Childbirth: The Case for a Physiologic Approach by Henci Goer, published 1/2012

Saturday AM, November 8, 9:30-1

Session Title__Conflict Resolution, the Gift of Nurturing and Supporting Families in the Quantum Paradigm_____

Session Length in minutes_____210 min.

1. Speakers Name(s): Whapio Diane Bartlett

2. Behavioral Objectives: Describe what the participants are expected to have learned from this program. Describe what knowledge or skills the learners will be able to demonstrate following the learning experience.

-Demonstrate the Circle of Nurturing as defined by the Matrona
-Demonstrate how to counsel families in psychology of Wounds and Power
-Demonstrate how to manage a group situation while supporting eldership and Win/Win Conflict Resolution

3. Session Content: Statements should support behavioral objectives listed above. List approximate minutes of time spent on each subject area.

-1 hour defining the Circle of Nurturing as taught by the Matrona
-1 hour defining the concepts of Wounds and Vulnerability as first presented by Caroline Myss
-1.5 hours defining the Conflict Resolution styles of Arnold Mindell

4. Assessment of Learner Outcome: Give examples of how learner achievement will be assessed (check all which will apply, including test Q's and A's).

Pre/Post Test Question	___Oral_____
Written/Oral Exam	_____
Demonstration of Skills	_____
Discussion	_____X_____
Projects	_____
Other	

_____

5. Three Pre and Post Session Test Questions and the Answers that the participant should have learned that directly relate to behavioral objectives.

1.What is the Caregivers Greatest Gift? How to nurture someone.
2. Can a caregiver be vulnerable and responsible at the same time? Yes
3. What are two other 'situations' that can be created in a mediation session other than Win/Win? Win/Lose and Collaboration

6. 5 current references from the past 4 years that you have used to prepare this session (texts and journal articles are acceptable). Be sure to include titles (journal and article where applicable) and publication dates.

Holistic Midwifery Vol. 1 by Anne Frye, CPM, revised edition published 9/2010
The New Pregnancy and Childbirth by Sheila Kitzinger, published 1/2011
Childbirth and the Future of Homo Sapiens by Michel Odent, MD published 11/2013
Optimal Care in Childbirth: The Case for a Physiologic Approach by Henci Goer, published 1/2012
Defy Gravity by Caroline Myss, published 1/2011

~LUNCH 1-2~

Saturday PM, November 8th, 2-5:30

Session Title__Cycles of Fertility and the Sacred Geometry of the Pelvis

Session Length in minutes_____210 min.

1. Speakers Name(s): Whapio Diane Bartlett

2. Behavioral Objectives: Describe what the participants are expected to have learned from this program. Describe what knowledge or skills the learners will be able to demonstrate following the learning experience.

- Teach the Cycles of Fertility to appropriate clients
-Demonstrate the anatomy of the female Pelvis
-Demonstrate why women have the full genetic potential of life at all times

3. Session Content: Statements should support behavioral objectives listed above. List approximate minutes of time spent on each subject area.

-1 hour defining the Cycles of Fertility
-1.5 hours defining the pelvic anatomy
-1 hour defining the ancestral physiology of the female body

4. Assessment of Learner Outcome: Give examples of how learner achievement will be assessed (check all which will apply, including test Q's and A's).

Pre/Post Test Question	___Oral_____
Written/Oral Exam	_____
Demonstration of Skills	_____
Discussion	_____X_____
Projects	_____

5. Three Pre and Post Session Test Questions and the Answers that the participant should have learned that directly relate to behavioral objectives.

1. What is the 'hormone of pregnancy'? Progesterone
2. What is the largest transverse diameter of a baby's head? Biparietal
3. What is the number of chromosomes in the Polar Body? 23

6. 5 current references from the past 4 years that you have used to prepare this session (texts and journal articles are acceptable). Be sure to include titles (journal and article where applicable) and publication dates.

Holistic Midwifery Vol. 1 by Anne Frye, CPM, revised edition published 9/2010
Anatomy and Physiology for Midwives 3rd Edition by Jane Coad, published 6/2011
Nurse Midwifery by Helen Varney, published 10/2013
Optimal Care in Childbirth: The Case for a Physiologic Approach by Henci Goer, published 1/2012
The New Pregnancy and Childbirth by Sheila Kitzinger, published 1/2011

Sunday AM, November 9th, 9:30-1

Session Title Cardinal Movements of Birth and the Holistic Stages of Labor

1. Speakers Name(s): Whapio Diane Bartlett

2. Behavioral Objectives: Describe what the participants are expected to have learned from this program. Describe what knowledge or skills the learners will be able to demonstrate following the learning experience.

-Demonstrate the Cardinal Movements of Birth
-Demonstrate the Clinical Model of Labor vs. the Holstic Stages of Labor
-Create a working model to apply to one's current practice on how to support women in the Second Stage of Labor without instructed 'pushing'

3. Session Content: Statements should support behavioral objectives listed above. List approximate minutes of time spent on each subject area.

-1 hour defining the Cardinal Movements of Labor
-1.5 hours defining the Holistic Stages of Labor
-1 hour defining the work of Constance Benyon

4. Give examples of how learner achievement will be assessed (check all which will apply, including test Q's and A's).

Pre/Post Test Question	___Oral_____
Written/Oral Exam	_____
Demonstration of Skills	_____
Discussion	_____X_____
Projects	_____

5. Three Pre and Post Session Test Questions and the Answers that the participant should have learned that directly relate to behavioral objectives

1. What is the first stage of the Holistic Stages of Labor? Embarkation
2. Does Constance Benyon encourage women to push during Second Stage of Labor? No
3. When does a woman's biochemistry recalibrate after birth according the Holistic Stages of Labor? During the Return

6. 5 current references from the past 4 years that you have used to prepare this session (texts and journal articles are acceptable). Be sure to include titles (journal and article where applicable) and publication dates.

Holistic Midwifery Vol. 1 by Anne Frye, CPM, revised edition published 9/2010
Anatomy and Physiology for Midwives 3rd Edition by Jane Coad, published 6/2011
Nurse Midwifery by Helen Varney, published 10/2013
Optimal Care in Childbirth: The Case for a Physiologic Approach by Henci Goer, published 1/2012
The New Pregnancy and Childbirth by Sheila Kitzinger, published 1/2011

~LUNCH 1-2~

Sunday PM, November 9th, 2-5:30

Session Title_The Postpartum

Session Length in minutes_____210 min.

1. Speakers Name(s): Whapio Diane Bartlett

2. Behavioral Objectives: Describe what the participants are expected to have learned from this program. Describe what knowledge or skills the learners will be able to demonstrate following the learning experience.

-Create a model of care that supports the Return, as defined in the Holistic Stages of Labor
-Demonstrate an accurate assessment of where the placenta is located after the birth of the baby, before the birth of the placenta
-Demonstrate how to do a Placenta Assessment/Reading

3. Session Content: Statements should support behavioral objectives listed above. List approximate minutes of time spent on each subject area.

-1 hour explaining in depth the Return as defined in the Holistic Stages of Labor
-1.5 hours defining the anatomy/physiology of the separation and birth of the placenta
-1 hour explaining the are of Placenta Assessments/Readings after birth

4. Give examples of how learner achievement will be assessed (check all which will apply, including test Q's and A's).

Pre/Post Test Question	___Oral_____
Written/Oral Exam	_____
Demonstration of Skills	_____
Discussion	_____X_____
Projects	_____

5. Lists Three Pre and Post Session Test Questions and the Answers that the participant should have learned that directly relate to behavioral objectives

1. When will a uterus rise post-birth? If there is a uterine hemorrhage
2. Is early cord clamping encouraged or discouraged according to recent midwifery based research? Discouraged
3. What is the common definition for a postpartum hemorrhage in terms of blood loss? 500 ml

6. 5 current references from the past 4 years that you have used to prepare this session (texts and journal articles are acceptable). Be sure to include titles (journal and article where applicable) and publication dates.

Holistic Midwifery Vol. 2 by Anne Frye, CPM, revised edited publication 11/2013
Anatomy and Physiology for Midwives 3rd Edition by Jane Coad, published 6/2011
Nurse Midwifery by Helen Varney, published 10/2013
Optimal Care in Childbirth: The Case for a Physiologic Approach by Henci Goer, published 1/2012
The New Pregnancy and Childbirth by Sheila Kitzinger, published 1/2011

ATTACHMENT 4

Whapio Diane Bartlett

---

18 Orange St
Apt 1B
Asheville, NC 28801
Belovedpilgrim@yahoo.com

Objective:

To teach and present information that I have learned over the course of 25 years as a home birth midwife and midwifery educator.

Education:

Bachelor's of Arts Degree
The College of St. Rose
Albany, NY 1968

Chi Gong & Tui Na Massage
Central Hospital
Beijing, China 1999

Hahnemann Academy of North America
Homeopathic Practicioner
1987-Current

Maternidad Zaragosa
Clinical Internship
El Paso, Texas 1985

Three Year Midwifery Apprenticeship
1981-1984

Employment:

Home Birth Midwife
1984-2000

Founded The Matrona Midwifery School
2000-Current
Director and Lead Instructor

Professional Career:

South East Women's Herbal Conference
Black Mountain, NC
Presenter--four times over the last ten years

MANA Conference
Chiapas, MX
Presenter--2008

Women's Journeys
Iquitos and Cusco, Peru
Director and Presenter--seven times since 2004

SQUATFest
San Fransisco, CA--2013
Presenter
Women of Color Week
Atlanta, GA
Director and Presenter--2013

Quantum Birthing Week
Mexico City, MX
Director and Presenter--2014

References:

Sarah Rathbone, CPM
828-301-0121

Joan Pinegar, Retired Home Birth Midwife
828-989-9647

Gena Kirby, Doula, Rebozo Instructor
503-741-0935

ATTACHMENT 5

Method of recording or reporting attendance or successful course completion

Attendance will be verified through a spreadsheet attendance form, with the information collected at the start time of the program each day. Upon completion participants will receive a certificate verifying attendance and contact hours.

The Matrona's business office, located at 1915 E Main St, D-123, Richmond, VA, 22333, will organize and store attendance records for the period of 7 years.

Director Report

Licensing and Fiscal Statistical Reports

Health Licensing Office

Board of Direct Entry Midwifery

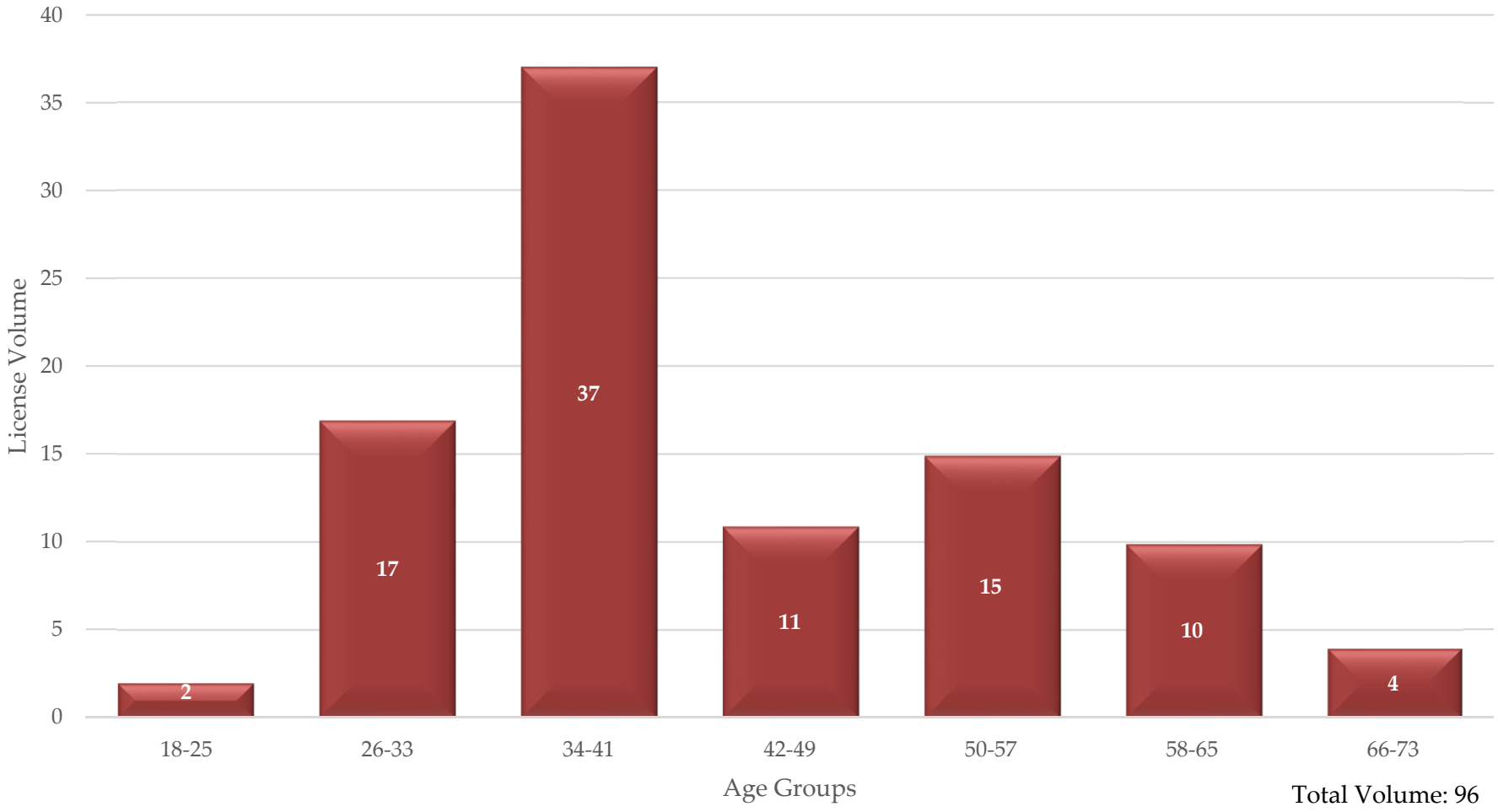
Licensing Division Statistics as of January 28, 2014

2013 - 2015 Biennium

Quarter	Licenses Issued	Renewals Processed	License Volume
1st	5	17	85
2nd	6	18	88
3rd	2	16	92
4th	8	23	93
5th	1	16	95
6th	6	24	88
7th	1	8	96
8th			
Total	**29**	**122**	

Active Midwifery License Volume

Statistics grouped by age as of January 28, 2015



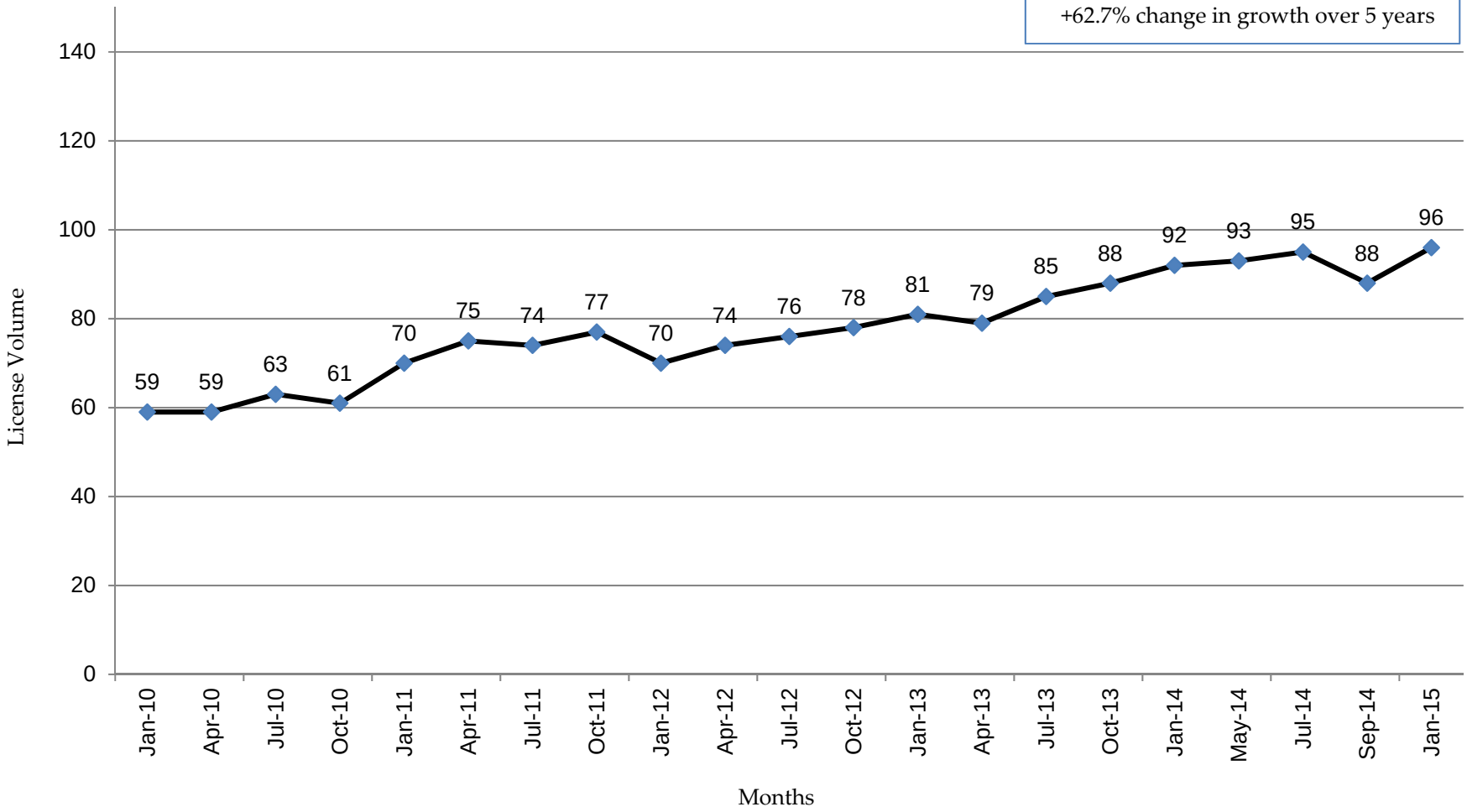
Total Volume: 96

Board of Direct Entry Midwifery

Active License Trend

January 2010 - January 2015

+4.3% change in growth over 1 year
+62.7% change in growth over 5 years



HEALTH LICENSING OFFICE
Fund 7810 - DIRECT ENTRY MIDWIFERY
STATEMENT OF CASH FLOW
FOR THE PERIOD 07/01/13 - 1/28/15

CURRENT

13-15' Beginning Cash Balance	$	(81,741.26)
Revenues	$	146,990.79
Expenditures	$	98,031.54
Less: Accrued Expenditures		
Less: Total Expenditures	$	(98,031.54)
Subtotal: Resources Available	$	(32,782.01)
Change in (Current Assets)/Liabilities	$	-
Ending Cash Balance (Actual)	**$**	**(32,782.01)**

Indirect Charges are calculated using the following rates:
*Based on Licensee Volume as of May 20, 2013

Shared Assessment %	0.10%
Examination %	0.00%
Small Board Qualification %	1.34%
Inspection %	0.00%

HEALTH LICENSING OFFICE
Fund 7810 - DIRECT ENTRY MIDWIFERY
STATEMENT OF CASH FLOW
FOR THE PERIOD 07/01/13- 06/30/15

PROJECTED

13-15' Beginning Cash Balance	$	(81,741.26)
Revenues	$	200,573.35
Expenditures	$	140,709.82
Less: Accrued Expenditures	$	-
Less: Total Expenditures	$	(140,709.82)
Subtotal: Resources Available	$	(21,877.73)
Change in (Current Assets)/Liabilities	$	-
Ending Cash Balance (Projection)	**$**	**(21,877.73)**

Indirect Charges are calculated using the following rates:
*Based on Licensee Volume as of May 20, 2013

Shared Assessment %	0.10%
Examination %	0.00%
Small Board Qualification %	1.34%
Inspection %	0.00%

Policy Report

2015 Legislation

Oregon Patient Safety Commission

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Early Discussion Resolution

Oregon Laws 2013, Chapter 5
Administrative Rules

325-035-0001
Definitions
As used in OAR 325-035-0001 to 325-035-0050:
(1) "**Adverse health care incident**" means an objective, definable and unanticipated consequence of patient care that is usually preventable and results in the death of or serious physical injury to the patient.
(2) "**Business day**" means any day other than a federal or State of Oregon legal holiday or a day other than a day on which offices of the State of Oregon are otherwise authorized by law to remain closed.
(3) "**Commission**" means the Oregon Patient Safety Commission.
(4) "**Discussion**" means:
(a) All communications, written and oral, that are made in the course of a discussion under Oregon Laws 2013, Chapter 5, Section 3; and
(b) All memoranda, work products, documents and other materials that are prepared for or submitted in the course of or in connection with a discussion under Oregon Laws 2013, Chapter 5, Section 3.
(5) "**Early Discussion and Resolution**" means the confidential process established in Oregon Laws 2013, Chapter 5 that includes, but is not limited to: the filing a notice of adverse health care incident with the Commission by a patient, health care provider or health care facility, discussions with all parties to seek resolution about the incident, and mediation if necessary to attempt to resolve the matter.
(6) "**Health care facility**" as defined in ORS 442.015 means a hospital, a long term care facility, an ambulatory surgical center, a freestanding birthing center, or an outpatient renal dialysis center.
(7) "**Health care provider**" means a person practicing within the scope of the person's license, registration or certification to practice as:
(a) A psychologist under ORS 675.030 to 675.070, 675.085 and 675.090;
(b) An occupational therapist under ORS 675.230 to 675.300;
(c) A physician under ORS 677.100 to 677.228;
(d) An emergency medical services provider under ORS chapter 682;
(e) A podiatric physician and surgeon under ORS 677.820 to 677.840;
(f) A registered nurse under ORS 678.010 to 678.410, including nurse practitioner;
(g) A dentist under ORS 679.060 to 679.180;
(h) A dental hygienist under ORS 680.040 to 680.100;
(i) A denturist under ORS 680.515 to 680.535;
(j) An audiologist or speech-language pathologist under ORS 681.250 to 681.350;
(k) An optometrist under ORS 683.040 to 683.155 and 683.170 to 683.220;
(l) A chiropractor under ORS 684.040 to 684.105;
(m) A naturopath under ORS 685.060 to 685.110, 685.125 and 685.135;
(n) A massage therapist under ORS 687.011 to 687.250;
(o) A direct entry midwife under ORS 687.405 to 687.495;
(p) A physical therapist under ORS 688.040 to 688.145;
(q) A medical imaging licensee under ORS 688.445 to 688.525;
(r) A pharmacist under ORS 689.151 and 689.225 to 689.285;
(s) A physician assistant under ORS 677.505 to 677.525; or
(t) A professional counselor or marriage and family therapist under ORS 675.715 to 675.835.
(8) "**Location operated by a health care facility**" means a satellite as defined by OAR 333-500-0010.

(9) "**Mediation**" as defined in ORS 36.110(5) means a process in which a mediator assists and facilitates two or more parties to a controversy in reaching a mutually acceptable resolution of the controversy and includes all contacts between a mediator and any party or agent of a party, until such time as a resolution is agreed to by the parties or the mediation process is terminated.
(10) "**Minor**" means anyone under the age of 18 but does not mean a minor who has been emancipated in accordance with ORS 419B.550 to 419B.558.
(11) "**Notice**" means a written or oral report, submitted by a patient, health care provider or health care facility to the Commission in the form and manner specified in OAR 325-035-0010, that indicates the filer's desire to engage in Early Discussion and Resolution.
(12) "**Party or Parties**" means any health care facility, health care provider, employer of a health care provider, and patient involved in the adverse health care incident.
(13) "**Patient**" means:
(a) The patient; or
(b) If the patient is a minor, is deceased or has been medically confirmed by the patient's treating physician to be incapable of making decisions for purposes of Oregon Laws 2013, Chapter 5, Sections 1 to 10, the patient's representative as provided in Oregon Laws 2013, Chapter 5, Section 8.
(14) "**Serious physical injury**" means an injury that:
(a) Is life threatening; or
(b) Results in significant impairment of a body function or significant damage to a body structure; or
(c) Necessitates medical or surgical intervention to prevent, mitigate or correct significant impairment of a body function or significant damage to a body structure.

325-035-0005
Filing a Notice of Adverse Health Care Incident
When an adverse health care incident occurs in a health care facility, a location operated by a health care facility, or outside a health care facility and the incident involves a health care provider, the health care facility, health care provider or employer of the health care provider, or a patient, may file a notice with the Commission in accordance with this rule. The filing of a notice enables the parties to engage in Early Discussion and Resolution.
(1) A notice may be filed with the Commission electronically, by telephone, or by submitting a written form prescribed by the Commission that contains the information described in sections (3) or (5) of this rule.
(2) A notice should not be filed with the Commission if:
(a) The incident does not meet the definition of an adverse health care incident;
(b) The adverse health care incident occurred before July 1, 2014;
(c) The adverse health care incident occurred outside of Oregon;
(d) The adverse health care incident did not involve at least one health care facility, location operated by a health care facility, or health care provider; or
(e) The filer is an inmate as defined in ORS 30.642.
(3) A notice filed by a health care facility, a health care provider, or an employer of a health care provider must include, but is not limited to:
(a) Incident date (this may be an approximation);
(b) Incident location; and
(c) Incident description.
(4) A notice filed by a health care facility or an employer of a health care provider shall not include the name of a health care provider.

(5) A notice filed by a patient must include, but is not limited to:
(a) Patient name;
(b) Patient date of birth;
(c) Incident date (this may be an approximation);
(d) Incident description;
(e) Incident location; and
(f) Adequate contact information for any health care facility or health care provider involved in the incident so the Commission may notify the facility or provider that a notice has been filed.
Stat. Auth.: Oregon Law 2013, Ch. 5, Secs. 2, 9
Stats. Implemented: Oregon Law 2013, Ch. 5, Secs. 2, 9

325-035-0010
Notifying a Health Care Facility, Health Care Provider, or Patient of a Notice of Adverse Health Care Incident
(1) When the Commission receives a notice from a patient, the Commission must notify all health care facilities and health care providers named in the notice, using email, telephone, or the US mail as appropriate. The Commission will attempt to contact all health care facilities and health care providers within seven business days of receiving the notice. If a patient is unable to provide accurate contact information for a health care facility or a health care provider, the Commission must attempt to notify the health care facility or health care provider and provide the required notice.
(a) If the Commission is not able to identify and contact a health care facility or a health care provider, the Commission must notify the patient in writing that unless accurate contact information for the health care facility or health care provider is received by the Commission within 30 days, the Commission will consider the matter closed.
(b) If the Commission does not receive accurate contact information for the health care facility or health care provider within 30 days, the Commission must inform the patient in writing that the Commission has closed the matter.
(2) A health care facility, health care provider, or employer of a health care provider who files a notice must:
(a) Provide a copy of the notice to the patient; and
(b) Notify any health care provider involved in the adverse health care incident of the notice.
(3) The Commission must notify a health care provider or health care facility of any notice that is filed by a patient, regardless of whether it appears that incident falls within the definition of an adverse health care incident. A health care provider or health care facility must make its own determination, after being notified by the Commission that a notice has been filed, as to whether the incident is an adverse health care incident such that the parties may engage in discussions.
Stat. Auth.: Oregon Law 2013, Ch. 5, Sec. 9
Stats. Implemented: Oregon Law 2013, Ch. 5, Secs. 2, 9

325-035-0015
Procedures for Conducting Discussions
(1) A health care facility, health care provider, or employer of a health care provider who files or is named in a notice of adverse health care incident and the patient who is the subject of the adverse health care incident may engage in Early Discussion and Resolution in an attempt to resolve the incident.

(2) If the parties choose to participate in Early Discussion and Resolution, the initial discussion should take place as soon as possible and generally within 72 hours of a health care facility or health care provider filing a notice or being informed by the Commission that a notice was filed by a patient, and conclude within 180 days of the initial filing of the notice.
(3) The parties may agree to extend the 180 day time limit described in section (2) of this rule if they also agree to extend the statute of limitations applicable to a negligence claim.
(4) Each party involved in Early Discussion and Resolution may include other persons in the discussion, including a mediator as outlined in OAR 325-035-0035.
(5) The health care facility, health care provider, or employer of a health care provider who chooses to participate in Early Discussion and Resolution must notify the patient and all other parties involved in the adverse health care incident of the date, time, and location of the discussions and shall reasonably accommodate all persons who have been invited to participate by the parties and wish to attend.
(6) Discussions may include:
(a) An explanation of what occurred and the implications for the patient's health and well-being;
(b) An explanation of the causes of the incident;
(c) An apology or expression of regret to the patient;
(d) The steps the health care facility or health care provider will take to prevent future occurrences of the adverse health care incident; and
(e) Compensation for the adverse health care incident.
(7) If the health care facility or health care provider is not going to make an offer of compensation, the health care facility or health care provider may communicate that to the patient orally or in writing.
(8) If compensation is offered, the offer must be in writing and the patient must be advised by the health care facility or health care provider of their right to seek legal advice before accepting the offer.
(9) Discussions and offers of compensation made in Early Discussion and Resolution:
(a) Do not constitute an admission of liability;
(b) Are confidential and may not be disclosed; and
(c) Except as provided in Oregon Laws 2013, Chapter 5, Section 3, are not admissible as evidence in any subsequent adjudicatory proceeding and may not be disclosed by the parties in any subsequent adjudicatory proceeding.
Stat. Auth.: Oregon Law 2013, Ch. 5, Sec. 3, 9
Stats. Implemented: Oregon Law 2013, Ch. 5, Secs. 3, 4, 9

325-035-0020
Filing Reports about Resolution
(1) The Commission must request a confidential report indicating the status of the matter from the person that filed the notice within 180 days after the notice was filed. If the matter is not resolved 180 days after the notice was filed, the Commission may request additional reports from the person that filed the notice as necessary.
(2) A report may include:
(a) Whether the matter has been resolved;
(b) Whether an apology was offered or there were expressions of regret;
(c) Whether the health care facility or health care provider agreed to take steps to prevent future occurrences of the adverse health care incident;
(d) How many oral communications, including face-to-face discussions, the parties have had;
(e) Who has participated in the oral communications, including face-to-face discussions;
(f) Whether the parties engaged in mediation; and
(g) Whether compensation was offered and accepted.

(3) If an offer of compensation is accepted by a patient at any point during discussions, the health care facility or provider must notify the Commission.
(4) If the parties to Early Discussion and Resolution resolve the matter, the person who filed the notice may submit a report about resolution as described in section (1) of this rule.
(5) If resolution is not achieved within 180 days, the Commission may request a report about resolution at a later date.
(6) The Commission may accept a report about resolution from an individual to whom the person who filed the notice has delegated authority to submit the report.
Stat. Auth.: Oregon Law 2013, Ch. 5, Sec. 9
Stats. Implemented: Oregon Law 2013, Ch. 5, Secs. 3, 9

325-035-0025
Mediation
(1) If a discussion as described in OAR 325-035-0015 does not result in the resolution of an adverse health care incident, the patient and the health care facility or health care provider who files or is named in a notice of adverse health care incident may enter into mediation.
(2) The parties who have agreed to participate in mediation shall bear the cost of mediation equally unless otherwise mutually agreed.
(3) Other persons that may participate in the mediation include, but are not limited to:
(a) Members of the patient's family, at the discretion of the patient;
(b) Attorneys for the patient, the health care facility and the health care provider;
(c) Professional liability insurance carriers;
(d) Risk management personnel; and
(e) Any lien holder with an interest in the dispute.
(4) Mediation under this rule is subject to ORS 36.110 through 36.238.
Stat. Auth.: Oregon Law 2013, Ch. 5, Sec. 9
Stats. Implemented: Oregon Law 2013, Ch. 5, Secs. 5, 9

325-035-0030
Adding a Mediator to the Mediator Panel
(1) The Commission must develop and maintain a panel of mediators that meet the qualifications established in this rule.
(2) To be included in the Commission's panel of mediators, an individual must meet the qualifications set forth is OAR 325-035-0035 and provide information to the Commission about themselves and their qualifications by completing and submitting the mediator panel application on the Commission's website (http://oregonpatientsafety.org). Information provided must include but is not limited to:
(a) Contact information;
(b) Education level;
(c) Number of mediations conducted, approximate number of hours of mediation experience, and approximate number of hours dealing with cases or matters involving medical malpractice or personal injury;
(d) General mediator training;
(e) Specific subject training;
(f) Continuing education;
(g) Professional standards of mediation practice to which the mediator adheres;
(h) Counties of Oregon that they are willing to serve;
(i) Languages spoken;
(j) Website links, if applicable; and

(k) Fee information.
Stat. Auth.: Oregon Law 2013, Ch. 5, Secs. 5, 9
Stats. Implemented: Oregon Law 2013, Ch. 5, Secs. 5, 9

325-035-0035
Mediator Qualifications
(1) The Commission will consider a mediator to have met the required qualifications if the individual has:
(a) Formally mediated 50 cases or engaged in 500 hours of formal mediation;
(b) Completed 30 hours of education meeting the standards in Appendix A or equivalent training;
(c) Received an orientation to Early Discussion and Resolution, made available by the Commission;
(d) Completed at least 16 additional hours of professionally accredited subject-specific training (which may include, but is not limited to: training related to medicine, health care, medical or hospital culture, health care transformation, mental health, grief counseling, psychology, risk management, key substantive, procedural or evidentiary laws relating to personal injury or adverse health care incidents, and adverse incident mediation discussion or role-playing);
(e) Have at least 150 hours of experience dealing with cases or matters that involve medical malpractice or personal injury as a mediator, facilitator, doctor, nurse, social worker, judge, consultant, psychologist, or attorney; and
(f) Provided the ethics and standards of practice to which they adhere.
(2) A mediator may request a waiver from the Commission from any mediator qualification. Such a request must be in writing and must describe why the qualification cannot be met and the facts that otherwise make the mediator qualified to be listed on the panel. The Commission may, in its discretion, waive a requirement for mediator qualification if it appears that the mediator has qualifications or the experience necessary to appropriately mediate matters involving adverse health care incidents.
Stat. Auth.: Oregon Law 2013, Ch. 5, Secs. 5, 9
Stats. Implemented: Oregon Law 2013, Ch. 5, Secs. 5, 9

325-035-0040
Publication of Mediator Panel
(1) If a mediator has submitted information in accordance with OAR 325-035-0030 and attested that he or she meets the qualifications in OAR 325-035-0035, the Commission must publish the mediator's name, contact information, and responses to questions asked on the mediator panel application on the Commission's website.
(2) Annually, the Commission must contact all listed mediators requesting that they update or confirm their information and qualifications. Mediators who do not confirm their information or continuing qualifications within the timeframe established by the Commission must be removed from the list, but may reapply for inclusion. Mediators may update or confirm their information at any time.
(3) If at any time the Commission discovers that a mediator does not meet qualifications, they will be removed from the list.
Stat. Auth.: Oregon Law 2013, Ch. 5, Sec. 9
Stats. Implemented: Oregon Law 2013, Ch. 5, Secs. 5, 9

325-035-0045
The Role of the Administrative Entity
(1) The Commission shall use notices of adverse health care incidents to:
(a) Establish quality improvement techniques to reduce patient care errors that contribute to adverse health care incidents;

(b) Develop evidence-based prevention practices to improve patient outcomes and disseminate information about those practices; and
(c) Upon the request of a health care facility or health care provider, assist the facility or provider in reducing the frequency of a particular adverse health care incident, including, but not limited to, determining the underlying cause of the incident and providing advice regarding preventing reoccurrence of the incident.
(2) The Commission may disseminate information relating to a notice of adverse health care incident to the public and to health care providers and health care facilities not involved in the incident as necessary to meet the goals described in section 1 of this rule. Information disclosed must not identify a health care facility, health care provider or patient involved in the adverse health care incident.
(3) The Commission may not disclose any information provided pursuant to a discussion under Oregon Laws 2013, Chapter 5, Section 3 to a regulatory agency or licensing board.
(4) The Commission may use and disclose information provided pursuant to a discussion under Oregon Laws 2013, Chapter 5, Section 3 as necessary to assist a health care facility or health care provider involved in an adverse health care incident in determining the cause of and potential mitigation of the incident. If the Commission discloses information under this section to a person not involved in the incident, the information may not identify a health care facility, health care provider or patient involved in the incident.
(5) The Commission will periodically disseminate aggregate information about incidents reported in notices and what has been learned about successful resolution. Additional information may be disseminated depending on data available.
Stat. Auth.: Oregon Law 2013, Ch. 5, Sec. 9
Stats. Implemented: Oregon Law 2013, Ch. 5, Secs. 9, 10

Appendix A

BASIC MEDIATION CURRICULUM

The basic mediation curriculum is a single curriculum that is designed to integrate the elements in this section consistent with any guidelines promulgated by the State Court Administrator. The basic mediation curriculum shall:

(1) Be at least 30 hours, or substantially similar training or education.

(2) Include training techniques that closely simulate the interactions that occur in a mediation and that provide effective feedback to trainees, including, but not be limited to at least six hours participation by each trainee in role plays with trainer feedback to the trainee and trainee self-assessment.

(3) Include instruction to help the trainee:

(a) Gain an understanding of conflict resolution and mediation theory;

(b) Effectively prepare for mediation;

(c) Create a safe and comfortable environment for the mediation;

(d) Facilitate effective communication between the parties and between the mediator and the parties;

(e) Use techniques that help the parties solve problems and seek agreement;

(f) Conduct the mediation in a fair and impartial manner;

(g) Understand mediator confidentiality and ethical standards for mediator conduct adopted by Oregon and national organizations; and

(h) Conclude a mediation and memorialize understandings and agreements.

(4) Be conducted by a lead trainer who has:

(a) Mediated at least 35 cases to conclusion or completed at least 350 hours of mediation experience beyond the experience required of a general civil mediator; and either

(b) Served as a trainer or an assistant trainer for the basic mediation curriculum outlined in this section at least three times; or

(c) Have experience in adult education and mediation as follows:

(A) Served as a teacher for at least 1000 hours of accredited education or training for adults; and

(B) Completed the basic mediation curriculum outlined under this section.

Excerpted from Oregon Judicial Department Court-Connected Mediator Qualifications Rules, Effective August 1, 2005.

Oregon Health Authority

Office of Health Policy Research

~

Integrative Medicine Advisory Board

http://transformationcenter.org/cco-resources/?keyword=&filter=integrative-medicine

Integrative Medicine Credentialing Information Tool

Integrative Medicine Advisory Group to the Oregon Health Authority

Winter 2014

The Integrative Medicine Credentialing Information Tool was created to facilitate information sharing by the integrative medicine professionals to their health system partners on key credentialing issues. The tool is intended to help demonstrate the ability of the disciplines to meet core-credentialing standards for participation in conventional payment and delivery systems, and includes information on the education, training and professional qualifications as required by their state health care regulatory boards.

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Integrative Medicine Credentialing Information Tool

Background

The Integrative Medicine Advisory Group (IMAG) was established in the fall of 2013, with the goal of advising the Director of the Oregon Health Authority (OHA) on ways to promote the use of complementary and alternative medical disciplines into Oregon's health care delivery system, including Coordinated Care Organizations (CCOs). The IMAG discusses key topics such as access, consumer choice, and quality of care, in support of the Triple Aim.

IMAG Membership

The IMAG consists of the five integrative medicine professions in Oregon that have a federally recognized accrediting agency[1] and a state-level health care regulatory board.[2] These include:

- Acupuncture and Oriental medicine
- Chiropractic
- Licensed direct-entry midwifery
- Massage therapy
- Naturopathic medicine

Additionally, IMAG representation has included two CCO medical directors and a commercial health plan medical director. The IMAG is staffed by Dr. Jeanene Smith, OHA's Chief Medical Officer, Dr. Wally Shaffer, Medical Director of OHA's Division of Medical Assistance Programs.

Integrative Medicine Credentialing Information Tool

The Credentialing Information Tool is intended to facilitate information sharing and education by integrative medicine professionals to their health system partners on key credentialing issues. The tool identifies common credentialing elements required and collected by key health care accrediting entities (e.g. The Joint Commission, The Centers for Medicare and Medicaid Services, etc.) relative to the five state health care regulatory boards. The tool has also been reviewed for accuracy by the state health care regulatory boards.

Elements used to verify providers' professional qualifications include, but are not limited to, relevant academic, professional and clinical training, licensure, certification and/or

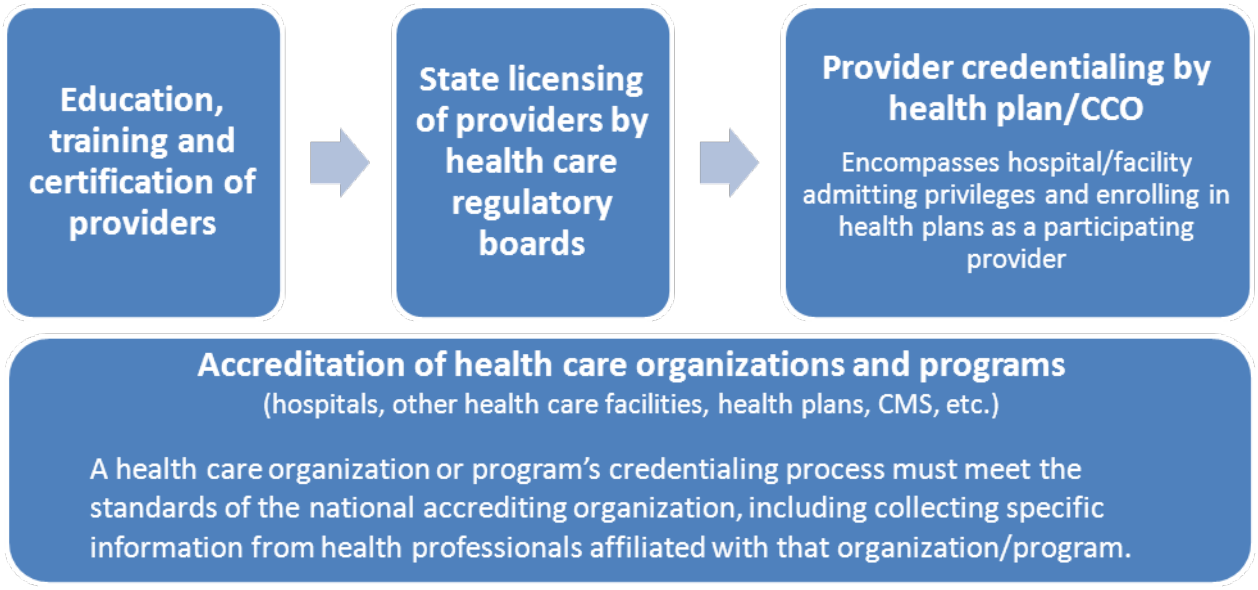
[1] The agencies that accredit the educational institutions for these professions have earned recognition by the United States Department of Education.

[2] The health care regulatory boards are responsible for licensure, examinations, and investigating complaints about the respective health professionals.

registration to practice in a health care field. Additionally, credentialing elements may include criteria relating to professional competence and conduct. This information is intended to demonstrate the ability of the integrative medicine professions to meet core-credentialing standards for participation in conventional payment and delivery systems.

The figure below is a high-level representation of the pathway to provider credentialing and a separate but parallel process for health care organization and program accreditation.

Figure 1. Pathway to Provider Credentialing



General Descriptions of the Integrative Medicine Professions

Unless noted otherwise, definitions and descriptions for the integrative medicine professions are derived from Oregon Revised Statutes (ORS) and/or Oregon Administrative Rule.

Acupuncture and Oriental Medicine

ORS 677.757

(1)(a) "Acupuncture" means an Oriental health care practice used to promote health and to treat neurological, organic or functional disorders by the stimulation of specific points on the surface of the body by the insertion of needles. "Acupuncture" includes the treatment method of moxibustion, as well as the use of electrical, thermal, mechanical or magnetic devices, with or without needles, to stimulate acupuncture points and acupuncture meridians and to induce acupuncture anesthesia or analgesia.

(b) The practice of acupuncture also includes the following modalities as authorized by the Oregon Medical Board: (A) Traditional and modern techniques of diagnosis and evaluation; (B) Oriental massage, exercise and related therapeutic methods; and (C) The use of Oriental pharmacopoeia, vitamins, minerals and dietary advice.

(2) "Oriental pharmacopoeia" means a list of herbs described in traditional Oriental texts commonly used in accredited schools of Oriental medicine if the texts are approved by the Oregon Medical Board. [1993 c.378 §1]

Chiropractic

ORS 684.010

(2) "Chiropractic" is defined as:

(a) That system of adjusting with the hands the articulations of the bony framework of the human body, and the employment and practice of physiotherapy, electrotherapy, hydrotherapy and minor surgery.

(b) The chiropractic diagnosis, treatment and prevention of body dysfunction; correction, maintenance of the structural and functional integrity of the neuro-musculoskeletal system and the effects thereof or interferences therewith by the utilization of all recognized and accepted chiropractic diagnostic procedures and the employment of all rational therapeutic measures as taught in approved chiropractic colleges.

The Guide to Policy and Practice Questions published by the State Board of Chiropractic Examiners[3] addressed the following primary care procedures as being within the scope of practice of a chiropractic physician:

- Annual physical exams
- Wellness annual counseling
- Screening and wellness blood work
- Resting electrocardiograms
- Lung function testing

[3] Available online at http://cms.oregon.gov/OBCE/publications/Guide_to_Policy_Practice.pdf. (Updated: May 23, 2013.)

- Nutritional counseling
- Obesity prevention and treatment

Licensed Direct Entry Midwifery

Midwives licensed in the State of Oregon render complete prenatal, intrapartum, and postpartum care to healthy women and their babies. Should the mother or baby develop risk factors during care, they consult or arrange for co-care/transfer of care as appropriate. They perform or order lab work, order ultrasounds, and administer or use legend and prescription drugs and devices as needed. They provide care in homes, clinics, and freestanding licensed birth centers.[4]

ORS 687.405

"Direct entry midwifery" defined. As used in ORS 687.405 to 687.495, "direct entry midwifery" means providing the following services for compensation:
(1) Supervision of the conduct of labor and childbirth;
(2) Providing advice to a parent as to the progress of childbirth;
(3) Rendering prenatal, intrapartum and postpartum care; and
(4) Making newborn assessments. [1993 c.362 §1; 2011 c.650 §4; 2013 c.657 §12]

Massage Therapy

ORS 687.011

(4) "Massage Therapy" means the use of pressure, friction, stroking, tapping or kneading on the human body, or the use of vibration or stretching on the human body by manual or mechanical means or gymnastics, with or without appliances such as vibrators, infrared heat, sun lamps or external baths, and with or without lubricants such as salts, powders, liquids or creams, for the purpose of, but not limited to, maintaining good health and establishing and maintaining good physical condition.[5]

Practice of Massage – OAR 334-010-0025

(1) Massage treatment may include, but is not limited to:
  (a) Client intake and assessment;
  (b) Practice of massage or bodywork;
  (c) Post massage assessment and recommendation; and
  (d) Documentation.
(2) Massage treatment does not include:
  (a) The application of high velocity/low amplitude force further defined as thrust techniques directed toward joint surfaces;
  (b) The use of equipment or devices that require a prescription; or
  (c) Making a medical diagnosis.

[4] Definition provided IMAG member who is a Licensed Direct Entry Midwife. June 2014.
[5] http://www.oregon.gov/OBMT/Documents/Revised%20Statutes%202013%20EDITION%20-%20Revised%2002.18.2014.pdf

Naturopathic Medicine

ORS 685.010

(4) “Naturopathic medicine” means the discipline that includes physiotherapy, natural healing processes and minor surgery and has as its objective the maintaining of the body in, or of restoring it to, a state of normal health.

(5) “Naturopathic physician” means a person who holds a degree of Doctor of Naturopathic Medicine and is licensed under this chapter. [Amended by 1953 c.557 §4; 1985 c.624 §3; 1989 c.575 §1; 1989 c.945 §3; 1993 c.42 §1; 1999 c.512 §1; 2003 c.154 §1; 2007 c.434 §1; 2009 c.43 §11; 2009 c.420 §1]

Integrative Medicine Accrediting, Licensing and Member Organizations

National Accrediting Entities Recognized by the U.S. Department of Education

Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM)
http://www.acaom.org/

Council on Naturopathic Medical (CNME)
http://www.cnme.org/

Council on Chiropractic Education (CCE)
http://www.cce-usa.org/

Commission on Massage Therapy Accreditation (COMTA)
http://www.comta.org/

Midwifery Education Accreditation Council (MEAC)
http://meacschools.org/

State Health Care Regulatory Boards

Oregon Board of Chiropractic Examiners
www.oregon.gov/OBCE

Board of Direct Entry Midwifery
www.oregon.gov/OHLA/DEM

Oregon Board of Massage Therapists
www.oregon.gov/OBMT

Oregon Board of Naturopathic Medicine
www.oregon.gov/obnm

Oregon Medical Board
http://www.oregon.gov/omb/licensing/Pages/Acupuncturist.aspx

State Member Associations

American Massage Therapy Association-Oregon Chapter
http://www.amta-or.org

Oregon Association of Acupuncture and Oriental Medicine
http://www.oaaom.com/

Oregon Association of Naturopathic Physicians
http://www.oanp.org/

Oregon Chiropractic Association
http://oregonchiroassoc.com/

Oregon Massage Therapists Association
http://www.omta.net/

Additional Resources

How to become an Oregon Health Plan provider
http://www.oregon.gov/oha/healthplan/Pages/providerenroll.aspx

OHA Provider Discrimination Review Process
http://www.dhs.state.or.us/policy/healthplan/guides/ohp/pdrc-process.pdf

Appendix A: Assessment of Accrediting Entity Credentialing Requirements and Health Care Regulatory Board Requirements

Please see Appendix A.

Appendix B: Integrative Medicine Provider Education, Training and Professional Requirements

Please see Appendix B.

Appendix A: Assessment of Accrediting Entity Credentialing Requirements and Health Care Regulatory Board Requirements

1/20/2015

	Accrediting Entity							Health Care Regulatory Boards					
Credentialing Data Element	**The Joint Commission** (Health Care Orgs.)	**DNV** (Hospitals)	**National Committee for Quality Assurance** (Health Plans)	**URAC** (Health Plans)	**Accreditation Assoc. for Ambulatory Health Care, INC.** (Health Care Orgs./Health Plans)	**CMS** (Medicare)	**CMS** (Medicaid)	**Oregon Practitioner Credentialing Application**	**Oregon Medical Board** (MDs, DOs, Podiatrists, PAs, Acupuncturists)	**Oregon Board of Naturopathic Medicine**	**State Board of Chiropractic Examiners**	**State Board of Massage Therapists**	**Board of Direct Entry Midwifery**
Identifying/ Practitioner Information	Valid Picture ID						x	x	x	x	x	x	x
Gender								x	x	x		x	x
Address Information							x	x	x	x	x	x	x
SSN and/or TAX ID							x	x	x	x	x	x	x
Citizenship and Alien Status								x		x			x
Immigrant Visa Information/Type								x					x
Foreign Education Equivalency Certification/Report	PSV	PSV	PSV	PSV				x	PSV				
Medical Specialty Information	x	x	x	x			x	x	x			x	
Practice Information							x	x	PSV	x			
Practice Call Coverage								x					
Undergraduate Education								x		PSV	x	*High school or equivalent*	*High school or equivalent*
Graduate Education								x		PSV			
Medical/Professional Education/Clinical Experience	PSV (State LB or Board cert. can be used)	PSV	PSV (Highest level of edu./training/ board cert.; state LB)	PSV (Highest level of edu./training/ board cert.; state LB)	PSV	PSV (Highest level of edu./training/ board cert.; state LB)	PSV (Highest level of edu./training/ board cert.; state LB)	x	PSV	PSV	x	x	Apprentice reqs (attend certain # of births, etc.
Post-Graduate Training (E.g. Internship, Residency, Fellowship)	PSV (AMA, AOAP)	PSV	PSV (State LB can be used)	PSV (Highest level of edu./training/ board cert.)	PSV	PSV (Highest level of edu./training/ board cert.)	PSV (Highest level of edu./training/ board cert.)	x	PSV	x			
Board Certification/ Recertification	x (PSV if required in bylaws, rules, and policies)		PSV	PSV	PSV	PSV	PSV	x	PSV	x			
State Licensing Information	PSV (State Licensing Board)	PSV	PSV (State LB)	PSV (State LB)	PSV	PSV (State LB)	PSV (State LB)	x	PSV	x		x	x
Hospital/Health Care Facility Affiliations	x		x	x	x			x	PSV				
Practice/Work History	x	x	x (5 yrs. min.)	x	x	x	x	x	PSV	x			x
Peer References	x	x			x			x	Occasionally		x	x	x
Continuing Medical Education (CME)	x	x						x	x	x	x	x	x
Drug Enforcement Administration (DEA) Registration Number		x	x (copy of DEA)	x (copy of DEA)	x			x		x			
Controlled Substance Registration (CSR) Number			x (copy of CSR)	x (copy of CSR)	x			x					
Professional Liability Insurance Information	Verified as required by medical bylaws	x	x (attestation or certificate of insurance)	x (attestation or certificate of insurance)	x	x (attestation or certificate of insurance)	x	x					Must disclose to patients if they have it or not
Disclosure of Sanctions, Discipline, Convictions	x		PSV (State LB, FSMB, NPDB)	x			x (OIG)	x	PSV	x			
Liability Claims/Lawsuits	PSV (NPDB)+B20	x	PSV (5-year hist. - NPDB or carrier)	PSV	x	PSV (NPDB or carrier)	x (NPDB)	x	PSV	x		x	
Individual National Provider Identifier (NPI) Number							x	x					
Foreign Languages									x				
Criminal Background Checks	x								PSV				
Required Attachments													

x = Required
FSMB = Federation of State Medical Boards
PSV = Primary Source Verification
NPDB = National Practitioner Data Bank
State LB = State Licensing Board
Note: If not otherwise indicated, credentialing element is not required, but may be collected.

Appendix B: Integrative Medicine Provider Education, Training and Professional Requirements

	Requirement	Doctor of Medicine	Acupuncturist and/or Oriental Medicine (AOM) Provider	Doctor of Naturopathic Medicine	Doctor of Chiropractic Medicine	Licensed Massage Therapist	Licensed Direct Entry Midwife
1	**Undergraduate Education Requirements**	4 years college or equivalent	2 Oregon schools have undergraduate requirements: • OCOM requires 3 years undergrad to be admitted. • NCNM requires 4 years undergrad to be admitted. The Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM) requires a minimum of 2 years undergraduate education. http://www.acaom.org/documents/	4 years of college with some additional educational for pre-requisite to enter Naturopathic program may be necessary.	Minimum 90 semester hours (three years) in undergraduate studies in the biological, physical and social sciences are required (ACCAHC 2013); bachelors degree preferred	N/A - High school or equivalent required	N/A - High school or equivalent required
2	**Graduate Education Requirements**	4 years medical school or equivalent	Two schools in Oreogn offer two degrees that qualify for licensure under the Oregon Medical Board). Any degree nationally must meet ACAOM standards. **OCOM offers:** • Master of Acupuncture and Oriental Medicine (4 year Masters program, comprehensive program in acupuncture and herbal medicine) • Doctor of Acupuncture and Oriental Medicine (advanced clinical doctorate degree, after Masters program) **NCNM offers:** • Master of Science in Oriental Medicine (comprehensive study in acupuncture and herbal medicine) • Master of Acupuncture (minimum requirements)	4 years graduate level Naturopathic medical school at college or university accredited by the Council on Naturopathic Medical Education (CNME)	Doctor of Chiropractic degree requires minimum 4200 classroom hours, typically delivered over a 4–5 academic years in an accredited program. Must include 36 hours in minor surgery/ proctology coursework either within the Graduate Education or Post Grad Education.	500 hours minimum of massage school	4 year degree in Midwifery. Most midwives who do not have such a degree began practicing prior to such schools (or licensing) existing.

	Requirement	Doctor of Medicine	Acupuncturist and/or Oriental Medicine (AOM) Provider	Doctor of Naturopathic Medicine	Doctor of Chiropractic Medicine	Licensed Massage Therapist	Licensed Direct Entry Midwife
3	**Licensing Exam**	United States Medical Licensing Examination (USMLE)	National Certification Commission for Acupuncture and Oriental Medicine http://www.nccaom.org/ To be licensed initially through the Oregon Medical Board, NCCAOM Certification is required.	National examinations to include Part I Basic Sciences; Part II Clinical Sciences; and Minor Surgery. North American Board of Naturopathic Examiners (NABNE) administers the Naturopathic Physicians Licensing Examinations (NPLEX); State-based Jurisprudence and Formulary law exams are required in Oregon. https://www.nabne.org/home/	National Board of Chiropractic Examiners' examination battery: NBCE Part 1: Basic Sciences; Part II: Clinical Sciences; Part III: Written Clinical Competency; Part IV: Practical Clinical Competency; State-based Jurisprudence and regulatory laws exams for each state	The board accepts three different types of written exams • National Certification Board for Therapeutic Massage and Bodywork (NCBTMB) • Massage & Bodywork Licensing Examination (MBLEx) • CSI In addition they must pass the Oregon Practical Exam	Evidence of current Certified Professional Midwife credential from the National American Registry of Midwives (NARM); or Passage of NARM exam w/in preceding 3 years of applying, official docs req.
4	**Medical/Professional Education, Clinical Experience**	Internship 1 year (all), residency based on specialty	Specified minimum number of observation hours and clinic hours are required by ACAOM for any Masters program in Acupuncture. http://www.acaom.org/documents/accreditation_manual_712.pdf Past minimum standard, varies by school. At OCOM, 236 hours are required of clinical observation and 732.5 hours are required over 1 year of internship.	2 years of clinical internship during medical school. 1,224 clock hours of direct patient contact.	Internship 1 year		Clinical Experience Reqs: •25 deliveries as an assistant •25 deliveries as primary birth attendant •Participation in 100 prenatal care visits •25 newborn exams, 40 postnatal exams •Have provided continuity of care for at least 10 primary birth attendant deliveries. Of 50 births, at least 25 deliveries must have taken place in an out-of-hospital setting; 10 births w/in 2 years of application.
5	**Post-Graduate Education Options**	Fellowships, certifications and other clinical training programs available	Doctoral AOM (DAOM) specialty certificates: e.g. NADA certification for proficiency in chemical dependency treatment http://www.acudetox.com/nada-training	1-3 year(s) outpatient residencies, certifications	Fellowships, certifications and other clinical training programs are available		

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6	**Medical Specialty Information**	Family practice, internal medicine, etc.	Several specialties are offered under the DAOM program. Most acupuncturists graduate from Masters programs highly proficient in treatment for chronic pain.	General practice, family medicine, women's health, sports medicine, etc.	Family medicine, sports medicine, radiology, orthopedics, etc.	Various modality specialties--trigger point, myofascial release, neuromuscular therapy, etc.	Supervision of the conduct of labor and childbirth; Providing advice to a parent as to the progress of childbirth; Rendering prenatal, intrapartum and postpartum care; and aking newborn assessments.
7	**Board Certification/ Recertification Body**	Board that certifies specific specialty (i.e. American Board of Family Medicine for family practice)	National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM)	Council on Naturopathic Medical Education (for general practice); American Board of Naturopathic Oncology (oncology)	Board that certifies specific specialty (i.e. ACBR for radiology)		
8	**Practice Setting/ Representative Organization**	Require the practive/ representative organization address not identification of practice type, whichmay include solo, group practice, employed, etc.	Require the practive/ representative organization address not identification of practice type, whichmay include solo, group practice, employed, etc.	Solo, group practice, employed, etc.	Solo, group practice, employed, etc.	Solo, group practice, employed, etc.	Solo, group practice, employed, etc.
9	**Federal Licensing Body**	DEA for narcotic license, CMS for NPI	N/A	DEA for narcotic license, CMS for NPI	CMS for NPI	N/A, CMS for NPI	National certification, state license, CMS for NPI
10	**State Licensing Body**	Oregon Medical Board www.oregon.gov/omb	Oregon Medical Board http://www.oregon.gov/omb/licensing/Pages/Acupuncturist.aspx	Oregon Board of Naturopathic Medicine www.oregon.gov/obnm	Oregon Board of Chiropractic Examiners www.oregon.gov/OBCE	Oregon Board of Massage Therapists www.oregon.gov/OBMT	Board of Direct Entry Midwifery www.oregon.gov/OHLA/DEM
11	**National Provider Identifier (NPI)**	Not currently required for licensure though OMB is moving in that direction.	Not currently required for licensure though OMB is moving in that direction.	Yes, required	Yes	Yes	Yes
12	**Drug Enforcement Administration (DEA) Registration**	Not required	Not required	Yes (optional)	Not required	N/A	Not required
13	**Controlled Substance Registration (CSR)**	Not required	Not required	DEA registration is sufficient to prescribe controlled substances that are within the scope of practice and listed on the formulary compendium	Not required	N/A	Not required

	Requirement	Doctor of Medicine	Acupuncturist and/or Oriental Medicine (AOM) Provider	Doctor of Naturopathic Medicine	Doctor of Chiropractic Medicine	Licensed Massage Therapist	Licensed Direct Entry Midwife
14	**Licensure, Registration, Certification or Other ID Numbers that Apply**	For licensure we do not require CME or Board certification unless certain statutory requirements dictate Other certifications include: ACLS, PALS, BLS, etc.	For licensure we do not require CME or Board certification unless certain statutory requirements dictate Other certifications include: ACLS, PALS, BLS, etc.	Certificataions include: ACLS, PALS, BLS, etc. (optional)	BLS	N/A	OR license #, NPI
15	**Continuing Medical Education (CME) Requirements for Licensure**	Yes	Regulated through Oregon Medical Board. Licensees must either a) Maintain active NCCAOM certification/ recertification or b) Maintain minimal number of CEUs per year, as subject to audit by OMB	Yes, 50 hours annually (with at least 10 in pharmacology, 2 in ethics); 15 hours in natural childbirth for those with natural childbirth certification.	Yes, 20 general subject hours annually, with some specific topics mandated (e.g. record keeping, boundaries, etc.)	Yes, 25 hours every 2 years	Yes
16	**Continuing Medical Education (CME) Reqs for Board Certification**	For licensure we do not require CME or Board certification unless certain statutory requirements dictate. Other certifications include: ACLS, PALS, BLS, etc.	For licensure we do not require CME or Board certification unless certain statutory requirements dictate.		Some, not all		
17	**Professional Liability Insurance Required?**	Usually, either individually, as part of practice, or employed under an umbrella policy. *Not required for licensure*	Usually required for employment or purposes of credentialing with specific insurance panels. *Not required for licensure.*	Not required for licensure; may be required by insurance companies, employer, or by individual	Most U.S. jurisdictions do not require liability insurance but highly recommended. Usually, either individually, as part of practice, or employed under an umbrella policy	Not required for licensure; may be required by insurance companies, employer, or by individual	Not required for licensure; must disclose status of malpractice insurance to potential clients. A signature is required from client agreeing to care in the absence of malpractice.
18	**Professional Liability Insurance Optional?**	Yes, i.e. maternity coverage for an FP that delivers babies. *Not required for licensure.*	Specialty practices. *Not required for licensure.*	Yes	Specialty practices-minor surgery, OB/GYN, etc.	Specialty practices--body cavity work other than nasal/oral, colonics, fire procedures (cupping, ear candling, etc.)	Yes

	Requirement	Doctor of Medicine	Acupuncturist and/or Oriental Medicine (AOM) Provider	Doctor of Naturopathic Medicine	Doctor of Chiropractic Medicine	Licensed Massage Therapist	Licensed Direct Entry Midwife
19	**Primary Sources for Bodies of Knowledge, Evidence, Standards of Care, Guidelines, Etc.**	Specialty societies, medical literature, practice specific guidelines, etc.	Specialty societies, medical literature, practice guidelines, classical texts	Specialty societies, medical literature, practice specific guidelines, etc.	Specialty societies, medical literature, practice specific guidelines, etc.	Specialty societies, medical literature, modality specific guidelines, etc.	Specialty societies, medical literature, practice specific guidelines, etc.
20	**Function as Primary Care Provider (PCP)?**	Specialty dependent	Not in Oregon currently	Primarily, but specialty dependent	Specialty dependent	Not required	Not required
21	**Hospital Affiliations**	Usually, but not always	Optional	Occasionally	Occasionally	Not required	Not required
22	**National Accrediting Agency (recognized by the US Department of Education.)**	Liaison Committee on Medical Education (LCME) or equivalent and Accreditation Council for Graduate Medical Education (ACGME) or equivalent.	Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM)	Council on Naturopathic Medical (CNME) under Department of Education	Institutions offering a Doctor of Chiropractic are members of the Association of Chiropractic Colleges (ACC) and are accredited by the Council on Chiropractic Educ. (CCE). All but 1 institution also holds regional accreditation.	Commission on Massage Therapy Accreditation (COMTA); as we only accept out of state transcripts if they are recognized by that State's Dept. of Education. If they are accredited by COMTA then they are recognized by that State's Dept. of Education. There are also other accreditation organizations.	Midwifery Education Accreditation Council (MEAC)

	Requirement	Doctor of Medicine	Acupuncturist and/or Oriental Medicine (AOM) Provider	Doctor of Naturopathic Medicine	Doctor of Chiropractic Medicine	Licensed Massage Therapist	Licensed Direct Entry Midwife
23	**Curriculum Content**		ACAOM-accredited acupuncture-only masters program minimum standard is a 3-4 yr. program and offers a first-professional master's degree or the first-professional master's level certificate or diploma; 1905 hrs: •705 didactic hrs in Oriental medical theory, diagnosis, and treatment techniques in acupuncture and related studies; •660 hrs in clinical training; •450 hrs in biomedical clinical sciences; and •90 hrs in counseling, communications, ethics and practice management. Professional Oriental medicine curriculum is a 4 yr. program, w/ training in acupuncture and additional study of Chinese herbal medicine, min. 2625 hours for a Master's degree or master's level certificate or diploma in Oriental medicine: •Min. 705 hrs in Oriental medical theory, diagnosis, and treatment techniques in acupuncture and related studies; •450 hrs in didactic Oriental herbal	4000+ hours in 4-year doctorate level program at a CNME accredited school	The chiropractic curriculum typically includes courses in: •Anatomy, Biochemistry, Physiology, Microbiology and Immunology, Pathology, Public Health, Clinical Skills (including history and physical examination) **Clinical and Laboratory Diagnosis** •Clinical Sciences (including the study of cardiopulmonary, gastrointestinal and genitourinary disorders; dermatology; ophthalmology; otolaryngology) •Gynecology and Obstetrics •Pediatrics •Geriatrics •Diagnostic Imaging (procedures and interpretation) •Psychology and Abnormal Psychology •Nutrition and Clinical Nutrition •Biomechanics •Orthopedics •Neurology •Emergency Procedures & First-Aid •Spinal Analysis •Principles and Practice of Chiropractic •Clinical Reasoning and Decision Making •Chiropractic Manual Therapy and	COMTA maintain curriculum competencies, but fewer than 10% of massage programs are accredited by COMTA. Therefore a wide variety in the type and quality of education. National Certification Board for Therapeutic Massage and Bodywork (NCBTMB) has a process for authorizing applicants to take the exams based on completion of: •125 hrs of instruction in the body's systems and anatomy, physiology and kinesiology •200 hrs in-class, supervised hands-on instruction in massage and bodywork assessment, theory and application instruction •40 hrs of pathology •10 hrs of business and ethics instruction (a min. of 6 hrs in ethics) •125 hrs of instruction in an area or related field that theoretically completes your massage program of study	See MANA Core Competencies for Basic Midwifery Practices.
24	**Training Compared to a Medical Doctor**			http://www.ncnm.edu/images/Factbook/Nat-Med-Ed-Comp-Curricula.pdf			
				http://aanmc.org/schools/comparing_nd_md_curricula/			

Health Evidence Review Commission

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Home Birth

February 5, 2015

http://www.oregon.gov/oha/herc/Pages/blog-home-birth.aspx

Department of Medical Assistant Program

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Exemption Request Risk Criteria

Comment accepted from January 1 to February 19, 2015

Hearing date February 17, 2015 at 10:30 a.m.

http://www.oregon.gov/oha/healthplan/Policies/Nprm-141-021715-Enrollment.pdf

Secretary of State

NOTICE OF PROPOSED RULEMAKING HEARING*

A Statement of Need and Fiscal Impact accompanies this form.

Oregon Health Authority, Division of Medical Assistance Programs (Division)	410
Agency and Division	Administrative Rules Chapter Number

Sandy Cafourek	500 Summer St Ne, Salem, OR 97301	503-945-6430
Rules Coordinator	Address	Telephone

RULE CAPTION

Rewrite OHP Enrollment Rules to Reflect Current Enrollment Practices Including Full Pregnancy Enrollment Exemption Process

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

February 17, 2015	10:30am	500 Summer St NE, Salem, OR 97301, Room 166	Sandy Cafourek
Hearing Date	Time	Location	Hearings Officer

Auxiliary aids for persons with disabilities are available upon advance request.

RULEMAKING ACTION

Secure approval of new rule numbers (Adopted or Renumbered rules) with the Administrative Rules Unit prior to filing.

ADOPT:

AMEND: OAR 410-141-3060 and OAR 410-141-0060

REPEAL: OAR 410-141-3060(T) and OAR 410-141-0060(T)

RENUMBER:

AMEND & RENUMBER:

Stat. Auth : ORS 413.042, 414.615, 414.625, 414.635 and 414.651

Other Auth.:

Stats. Implemented: ORS 414.725, 414.610–414.685

RULE SUMMARY

These rules provide the framework for Coordinated Care Organization (CCO) and Managed Care Organization (MCO) enrollment requirements, including any existing exemptions from CCO and MCO enrollment. The Authority requested stakeholder and public comment on the following: The Licensed Direct Entry Midwives (LDEM) Staff Advisory Workgroup came out with recommendations related to perinatal service options for Medicaid enrollees. The Authority Director, Suzanne Hoffman responded with a Letter dated May 21, 2014, stating the Division would implement changes, necessitating the removal of the sunset date, allowing for time to make further program implementations and additional rule revisions. It has been decided to implement the CCO enrollment exemption criteria on which to build additional program specific criteria later in 2015 outlining the detail level of the program requirements.

February 19, 2015 by 5 p.m. Send comments to: dmap.rules@state.or.us

Last Day for Public Comment (Last day to submit written comments to the Rules Coordinator)

Rhonda Busek	Rhonda Busek	12-3-14
Signature	Printed name	Date

*Hearing Notices published in the Oregon Bulletin must be submitted by 5:00 pm on the 15th day of the preceding month unless this deadline falls on a weekend or legal holiday, upon which the deadline is 5:00 pm the preceding workday. ARC 920-2005

Secretary of State

STATEMENT OF NEED AND FISCAL IMPACT

A Notice of Proposed Rulemaking Hearing or a Notice of Proposed Rulemaking accompanies this form.

Oregon Health Authority, Division of Medical Assistance Programs — 410

Agency and Division — Administrative Rules Chapter Number

RULE CAPTION

Rewrite OHP Enrollment Rules to Reflect Current Enrollment Practices Including Full Pregnancy Enrollment Exemption Process

(Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of: The amendment of OAR 410-141-3060 and OAR 410-141-0060

Statutory Authority: ORS 413.042, 414.615, 414.625, 414.635 and 414.651
Other Authority:
Stats. Implemented: ORS 414.610–414.685

Need for the Rule(s): The Division needs to amend these rules to align the rules with current enrollment requirements for CCOs and MCOs. Additionally, the Division has removed the sunset date of July 1, 2014, for the third trimester pregnancy CCO enrollment exemption. The CCO enrollment exemption will shift from third trimester only to spanning the entire length of pregnancy, effective January 1, 2015, through a temporary rule. This permanent rule will provide the remainder of CCO and MCO enrollment criteria relative to high risk home births initiated with the January 1, 2015 temporary rule. OAR 410-141-0060 will receive alignment with OAR 410-141-3060 and general rule review for applicability.

Documents Relied Upon, and where they are available:

- The Licensed Direct Entry Midwives (LDEM) Staff Advisory Workgroup came out with recommendations related to perinatal service options for Medicaid enrollees. The Authority Director Suzanne Hoffman responded with a letter dated May 21, 2014, stating the Division would implement changes necessitating the removal of the sunset date and allowing for time to make further program implementations and additional rule revisions.
- Minutes from the May 27, 2014 Medical Management Committee meeting. Minutes are available through DMAP. These materials can be found as follows: I:\DMAP Policy and Planning Section PPS Admin\Medical Management Committee Meeting

Fiscal and Economic Impact:

- Re: 410-141-3060-No significant fiscal impact is anticipated with this rule change. No change is anticipated to the total number of births that OHP pays for. Home births are generally paid for fee-for-service (FFS) and not from CCO budgets. It is unknown if FFS will gain a few more low risk less costly births leaving a few more high risk high cost births to be paid for by CCOs. It is anticipated that if a shift in numbers between FFS and CCO it will be very slight and will not have a significant fiscal impact.
- Revisions to 410-141-0060 will have no fiscal impacts.

Statement of Cost of Compliance: None anticipated

2. Cost of compliance effect on small business (ORS 183.336): None anticipated
a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule:
None anticipated
b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services:
None anticipated
Amending these rules will not add additional reporting, record keeping or other administrative activities.
c. Equipment, supplies, labor and increased administration required for compliance:. None anticipated

How were small businesses involved in the development of this rule? Small businesses were invited to participate in the RAC

Administrative Rule Advisory Committee consulted? : Yes, Nov. 10, 2015 If not, why? :

Rhonda Busse — Rhonda Busse — 12-3-14

Signature — Printed name — Date

Administrative Rules Unit, Archives Division, Secretary of State, 800 Summer Street NE, Salem, Oregon 97310.

Current rule as of 1/1/15

410-141-0060

Oregon Health Plan Managed Care Enrollment Requirements

(1) For the purposes of this rule, the following definitions apply:

(a) Client means an individual found eligible to receive health services. “Client” is inclusive of members enrolled in PHPs and CCOs as stated in OAR 410-120-0000;

(b) Eligibility Determination means an approval or denial of eligibility and a renewal or termination of eligibility as stated in OAR 410-200-0015;

(c) Member means a client enrolled with a pre-paid health plan or coordinated care organization as stated in OAR 410-120-0000;

(d) Newly Eligible means recently determined through the eligibility determination process as having the right to obtain state health benefits, satisfying the appropriate conditions;

(e) Redetermination means a review of eligibility outside of regularly scheduled renewals. Redeterminations that result in the assignment of a new renewal date or a change in program are considered renewals as stated in OAR 410-200-0015;

(f) Renewal means a regularly scheduled periodic review of eligibility resulting in a renewal or change of program benefits, including the assignment of a new renewal date or a change in eligibility status.

(2) The following populations may not be enrolled into an MCO or any type of health care coverage including:

(a) Persons who are non-citizens and are Citizen/Alien Waivered-Emergency Medical program eligible for labor and delivery services and emergency treatment services;

(b) Clients receiving premium assistance through the Specified Low-Income Medicare Beneficiary, Qualified Individuals, Qualified Disabled Working Individuals and Qualified Medicare Beneficiary programs without other Medicaid;

(c) Persons who are dually eligible for Medicare and Medicaid and enrolled in a program of all-inclusive care for the elderly.

(3) The following populations may not be enrolled into an MCO under the following circumstances:

(a) Newly eligible clients are exempt from enrollment with an MCO but not exempt from enrollment in a DCO, if they became eligible when admitted as an inpatient in a hospital. The client shall receive health care services on a fee-for-service (FFS) basis only until the hospital discharges the client. The individual will receive dental services through the DCO.

(b) The client is covered under a major medical insurance policy or other third party resource (TPR) that covers the cost of services to be provided by a PHP as specified in and ORS 414.631 and, except as provided for children in Child Welfare though the BRS and PRTS programs, outlined OAR 410-141-3050. A client shall be enrolled with a DCO even if they have a dental TPR.

(4) Persons who are documented American Indian and Alaskan Native (AI/AN) beneficiaries are exempt from auto assignment mandatory enrollment for their managed care plans, as specified in 42 USC 1932, 2 (C), but may elect to be manually enrolled.

(5) Populations specified below are exempt from mandatory enrollment into a physical health MCO but are subject to mandatory enrollment into both dental and mental health plans as available in the member's service area. The member may be manually enrolled into a physical health plan as deemed appropriate by the Authority. These individuals are as follows:

(a) Children in the legal custody of the Department or Oregon Health Authority where the child is expected to be in a substitute care placement for less than 30 calendar days unless:

(A) Access to health care on a FFS basis is not available; or

(B) Enrollment would preserve continuity of care.

(b) Clients who are dually eligible for Medicare and Medicaid but not enrolled in a program of all-inclusive care for the elderly. The following apply to these clients:

(A) A client who is also a Medicare beneficiary and is in a hospice program may not enroll in an FCHP or PCO that is also a Medicare Advantage plan. The client may enroll in either an FCHP or PCO that does not have a Medicare Advantage plan unless exempt for some other reason listed in this rule;

(B) The client is enrolled in Medicare and the only FCHP or PCO in the service area is a Medicare Advantage plan. The client may choose not to enroll in an FCHP or PCO;

(C) Enrollment in a FCHP or PCO of a client who is receiving Medicare and who resides in a service area served by PHPs shall be as follows:

(i) If the client who is Medicare Advantage eligible selects a FCHP or PCO that has a corresponding Medicare Advantage plan, the client shall complete the 7208M or other CMS approved Medicare plan election form;

(ii) If the Medicare Advantage Plan Election form (OHP 7208M) described in this rule is signed by someone other than the client, the client's representative must complete and sign the Signature by Mark or State Approved Signature sections of the OHP 7208M;

(iii) If the client is a Medicare beneficiary who is capable of making enrollment decisions, the client's representative may not have authority to select FCHPs or PCOs that have corresponding Medicare Advantage components:

(I) If the FCHP or PCO has not received the form within ten calendar days after the date of enrollment, the FCHP or PCO shall send a letter to the member with a copy sent to the APD branch manager. The letter shall explain the need for the completion of the form; inform the member that if the form is not received within 30 days, the FCHP or PCO may request disenrollment; and instruct the member to contact their caseworker for other coverage alternatives.

(II) The FCHP or PCO shall choose whether to disenroll or maintain enrollment for all the clients from whom they do not receive a form at the end of 30 days, except as otherwise provided in this rule. The FCHP or PCO shall notify the PHP coordinator of the PHP's annual decision to disenroll or maintain enrollment for the clients in writing. This notification shall be submitted by January 31 of each year or another date specified by the Authority. If the FCHP or PCO has decided to:

(III) Disenroll the clients and has not received a client's form at the end of 30 days, the FCHP or PCO shall request disenrollment. HMU will disenroll the member effective the end of the month following the notification;

(D) Maintain enrollment. The FCHP or PCO may not request disenrollment at the end of 30 days.

(E) If the client is enrolled as a private member of a Medicare Advantage plan, the client may choose to remain enrolled as a private member or to enroll in the FCHP or PCO that corresponds to the Medicare Advantage plan:

(F) If the client chooses to remain as a private member in the Medicare Advantage plan, the client shall remain in the Medicaid FFS delivery system for physical health care services but shall select a DCO and MHO where available;

(G) If the client chooses to discontinue the Medicare Advantage enrollment and then, within 60 calendar days of disenrollment from the Medicare Advantage plan, chooses the FCHP or PCO that corresponds to the Medicare Advantage plan that was discontinued, the client shall be allowed to enroll in the FCHP or PCO even if the FCHP or PCO is not open for Enrollment to other clients;

(H) A Fully Dual Eligible (FDE) client who has been exempted from enrollment in an MHO may not be enrolled in a FCHP or PCO that has a corresponding Medicare Advantage plan unless the exemption was done for a provider who is on the FCHP's or PCO's panel.

(6) The Authority may temporarily exempt clients from mandatory enrollment for other just causes as determined by the Authority through medical review. The Authority may set an exemption period on a case-by-case basis for those as follows:

(a) Children under 19 years of age who are medically fragile and who have special health care needs. The Authority may enroll these children in MCOs on a case-by-case basis; children not enrolled in a MCO shall continue to receive services on a FFS basis;

(b) Until December 31, 2017, women who are pregnant and meet the qualifications in sub-sections A through E below may receive OHP benefits on a FFS basis for physical health only until 60 days after the birth of her child. Women meeting the criteria for the pregnancy enrollment exemption for their physical health plan coverage will continue to be enrolled in the appropriate MCO or CCO plan in their service area for dental and mental health coverage. After the 60 day period, the member shall enroll in a plan as appropriate. Those women under consideration for a pregnancy enrollment exemption for their physical health enrollment shall receive a response from the Authority within 30 working days of request. Upon approval of the FFS pregnancy exemption for physical health enrollment only, the client shall remain FFS for as long as she continues to meet the requirements in A through E below. In order to qualify for the FFS pregnancy exemption for physical health only, there shall be no home birth option available to the client through her plan and the client shall:

(A) Be pregnant;

(B) State that her intention is to have a home birth;

(C) Have an established relationship for the purpose of home birth with a licensed qualified practitioner who is not a participating provider with the client’s MCO;

(D) Make a request to change to FFS. This request can be made at any point in the pregnancy prior to delivery; and

(E) Meet any OAR and statutory requirements that define when a home birth is eligible for reimbursement by the Authority:

(i) Should a woman become unable to meet any of the requirements specified in OAR 333-076-0650(1), Table 1, either upon initial evaluation or once the exemption is granted, the exemption shall be withdrawn, and the client will be subject to MCO enrollment requirements as stated in 410-141-3060;

(ii) Conditions arising during the pregnancy as listed in subsections (I) through (V) below shall be reviewed by the Authority on a case-by-case basis for continuation of the FFS enrollment exemption:

(I) Fetal presentation other than vertex when known;

(II) Abnormal bleeding;

(III) Low-lying placenta within 2 cm. or less of cervical os;

(IV) Genital herpes, primary; secondary uncoverable at onset of labor; and

(V) Current substance abuse that has the potential to adversely affect labor and the infant.

(c) The following apply to clients and exemptions relating to organ transplants:

(A) Newly eligible clients are exempt from enrollment with an MCO if the client is newly diagnosed and under the treatment protocol for an organ transplant;

(B) Newly eligible clients with existing transplants shall enroll into the appropriate MCO for their service area;

(d) Other just causes to preserve continuity of care include the following considerations:

(A) Enrollment would pose a serious health risk; and

(B) The Authority finds no reasonable alternatives.

(7) Unless exempted above, enrollment is mandatory in all areas served by an MCO.

(8) When a service area changes from mandatory to voluntary, the member will remain with their PHP for the remainder of their eligibility period unless the member meets the criteria stated in this rule or as provided by OAR 410-141-0080.

(9) If the client resides in a mandatory service area and fails to select a DCO, MHO, PCO, or FCHP at the time of application for the OHP, the Authority shall enroll the client with a DCO, MHO, PCO, or FCHP as follows:

(a) The client shall be assigned to and enrolled with a DCO, MHO, PCO, or FCHP that meets the following requirements where MCO enrollment is not available or services are not available through the MCO:

(A) Is open for enrollment;

(B) Serves the county in which the client resides;

(C) Has practitioners located within the community-standard distance for average travel time for the client.

(b) Assignment shall be made first to an MCO;

(c) The Authority shall send a notice to the client informing the client of the assignments and the right to change assignments within 30 calendar days of enrollment. A change in assignment shall be honored if there is another DCO, MHO, PCO, or FCHP open for enrollment in the county in which the client resides;

(10) Clients shall be enrolled with PHPs according to the following criteria:

(a) Areas with sufficient physical health service capacity through a combination of Coordinated Care Organizations (CCOs), Fully Capitated Health Plans (FCHP), and Physician Care Organizations (PCO) shall be called mandatory service areas. In mandatory service areas, a client shall select:

(A) A CCO; or

(B) An FCHP or PCO:

(i) If the client has an existing relationship with a provider who is contracted with the FCHP or PCO; and

(ii) If approved by the Authority.

(b) Service areas without sufficient physical health service capacity shall be called voluntary service areas. In voluntary service areas, a client has the option to:

(A) Select a CCO; or

(B) Select an FCHP or PCO;

(i) If the client has an existing relationship with a provider who is contracted with the FCHP or PCO; and

(ii) If approved by the Authority; or

(C) Remain in the Medicaid fee-for-service (FFS) physical health care delivery system.

(c) Service areas with sufficient mental health and dental care service capacity through MHOs and DCOs shall be called mandatory MHO and DCO service areas. A client shall select an MHO and DCO in a mandatory MHO and DCO service area if mental health and dental services are not available through a CCO or the client is otherwise exempt from CCO enrollment;

(d) Service areas without sufficient dental care service capacity through MHOs and DCOs shall be called voluntary MHO and DCO service areas. In voluntary MHO and DCO service areas, a client may choose to:

(A) Select a CCO open to enrollment that offers dental services; or

(B) Select any MHO and DCO open for enrollment if CCO enrollment is not available; or

(C) Remain in the Medicaid FFS mental health and dental care delivery system;

(11) Enrollments resulting from assignments shall be effective the first of the month or week after the Department enrolls the client and notifies the client of enrollment and the name of the PHP: If enrollment

is initiated by an Authority worker on or before Wednesday, the date of enrollment shall be the following Monday. If enrollment is initiated by an Authority worker after Wednesday, the date of enrollment shall be one week from the following Monday. Monthly enrollment in a mandatory service area, where there is only one plan or DCO, shall be initiated by an auto-enrollment program of the Authority, effective the first of the month following the month-end cutoff. Monthly enrollment in service areas, where there is a choice of PHPs, shall be auto-enrolled by computer algorithm.

(12) The provision of capitated services to a member enrolled with a PHP shall begin as of the effective date of enrollment with the MCO except for:

(a) A newborn whose mother was enrolled at the time of birth. The date of enrollment shall be the newborn's date of birth;

(b) Persons, other than newborns, who are hospitalized on the date enrolled. The date of enrollment shall be the first possible enrollment date after the date the client is discharged from inpatient hospital services;

(c) For members who are re-enrolled within 30 calendar days of disenrollment, the date of enrollment shall be the date specified by the Authority and may be earlier than the effective date outlined above.

Stat. Auth.: ORS 413.042, 414,615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 & 414.685
Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 7-1994, f. & cert. ef. 2-1-94; HR 8-1994(Temp), f. & cert. ef. 2-1-94; DEQ 24-1994, f. 5-31-94, cert. ef. 6-1-94; HR 33-1994, f. & cert. ef. 11-1-94; HR 39-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1995, f. 9-28-95, cert. ef. 10-1-95; HR 19-1996, f. & cert. ef. 10-1-96; HR 21-1996(Temp), f. & cert. ef. 11-1-96; HR 29-1996(Temp), f. 12-31-96, cert. ef. 1-1-97; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 21-1998, f. & cert. ef. 7-1-98; OMAP 49-1998(Temp), f. 12-31-98, cert. ef. 1-1-99 thru 6-30-99; Administrative correction 8-9-99; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 29-2001, f. 8-13-01, cert. ef. 10-1-01; OMAP 12-2002, f. & cert. ef. 4-1-02; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 10-2006(Temp), f. & cert. ef. 5-4-06 thru 10-27-06; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 46-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 72-2014(Temp), f. 12-9-14, cert. ef. 1-1-15 thru 6-29-15

333-076-0650

Service Restrictions

(1) Procedures permitted, including surgical procedures, must be limited to those directly pertaining to pregnancy, labor and delivery care of women experiencing low risk pregnancy. Procedures performed will be consistent with the individual practitioner's licensure and/or scope of practice. Tubal ligation and abortion must not be performed. Table I outlines absolute risk factors that, if present on admission to the birthing center for labor and delivery, would prohibit admission to the birthing center. Table II outlines absolute risk factors that, if they develop during labor and delivery, require transfer of the client to a higher level of care. Table III outlines absolute risk factors that, if they develop during the postpartum period in the mother or infant, would require transfer to a higher level of care.

(2) General, spinal, caudal, and/or epidural anesthesia must not be administered in the Center.

(3) Labor shall not be induced, stimulated, or augmented with chemical agents during the first or second stages of labor.

(4) Chemical agents may be administered within the individual practitioner's scope of practice to inhibit labor, as a temporary measure, until referral/transfer of the client is complete.

Stat. Auth.: ORS 441.025 & 442.015
Stats. Implemented: ORS 441.025 & 442.015
Hist.: HD 26-1985, f. & ef. 10-28-85; HD 2-1990, f. 1-8-90, cert. ef. 1-15-90, Renumbered from 333-076-0415; PH 15-2006, f. & cert. ef. 6-27-06

OAR 333-076-0650(1) BIRTHING CENTERS ABSOLUTE RISK FACTORS

TABLE I - ADMISSION

ABSOLUTE RISK FACTORS that if present on admission to the Birthing Center for labor & delivery would prohibit admission to the Birthing Center:

- Current substance abuse which has the potential to adversely affect labor and/or the infant
- Quadriplegia
- Hypertension >150/100 on at least two occasions
- For this pregnancy, Type I Diabetes, other diabetes requiring insulin to maintain acceptable control, or Type II Diabetes
- Thrombosis, active/current
- Severe anemia, <9 hemoglobin
- Uncontrolled seizure disorder
- Life-threatening congenital defects in fetus. This does not include documented lethal anomalies
- History of previous uterine wall surgery, including Caesarean section, if one or more of the following risk factors is present:
  - Conception occurred < 12 months following that surgery or uterine procedure;
  - Absence of ultrasound to rule out placenta previa and/or placental attachment to the surgical site;
  - History of two or more Caesarean sections without a prior successful vaginal delivery;
  - History of myomectomy which invaded the endometrium;
  - History of a known uterine perforation;
  - History of Caesarean section which included classical incision;
  - History of Caesarean section and complications including postoperative infection, diabetes, or steroid use;
  - Absence of signed, detailed informed consent

NOTE: Any woman with previous uterine wall surgery must be evaluated for the presence of risk factors, and must go through an informed consent process. The Information given to the woman must Include an explanation of the risk, including non-absolute risks, of a vaginal birth after Caesarean section, and an explanation of the contingency plan in place should transport be necessary. If transport becomes necessary, the birthing center should notify the receiving facility when the transport is imminent.

OAR 333-076-0650(1) BIRTHING CENTERS ABSOLUTE RISK FACTORS
TABLE I - ADMISSION (continued)

- Need for Caesarean delivery this birth
- Multiple gestation
- Intrauterine growth restriction without reassuring bio-physical profile of greater than or equal to 8 out of 10
- No previous prenatal care or written prenatal records available
- Abnormal fetal surveillance studies
- Fetal presentation other than vertex, when known
- Rising antibody titre - types known to affect fetal well-being; significant Rh sensitization
- Amniotic fluid index >30 at term
- Amniotic fluid index <5 without reassuring labor progress, without reassuring fetal heart tones and/or abnormal non-stress test
- Abnormal bleeding
- Need for chemical and/or pharmacological induction of labor
- Need for general or conduction anesthesia
- Eclampsia; preeclampsia with lab abnormalities
- LOW-lying placenta within 2 cm. or less of cervical os; vasa previa; complete placenta previa; abruptio placenta
- Genital herpes, primary; secondary uncoverable at onset of labor
- Labor or premature rupture of membranes at <36 weeks; pregnancy >43 weeks or >42 weeks with abnormal non-stress test
- Chorioamnionitis
- Thick meconium-stained amniotic fluid without reassuring Doppler heart tones
- Known pre-term fetal demise

Oregon Health Authority, Public Health

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Patient Choice

Secretary of State
Certificate and Order for Filing

TEMPORARY ADMINISTRATIVE RULES

A Statement of Need and Justification accompanies this form.

FILED
8-7-14 8:52 AM
ARCHIVES DIVISION
SECRETARY OF STATE

I certify that the attached copies are true, full and correct copies of the TEMPORARY Rule(s) adopted on Upon filing. by the

Oregon Health Authority, Public Health Division — 333

Agency and Division — Administrative Rules Chapter Number

Brittany Sande — (971) 673-1291

Rules Coordinator — Telephone

800 NE Oregon St., Suite 930, Portland, OR 97232

Address

To become effective 08/07/2014 through 01/24/2015.

RULE CAPTION

Addition of clarifying language to previously filed temporary rules in regards to patient notification

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

RULEMAKING ACTION

Secure approval of new rule numbers with the Administrative Rules Unit prior to filing.

ADOPT:

AMEND:
333-072-0215

SUSPEND:

Statutory Authority:
ORS 441.098

Other Authority:

Statutes Implemented:
ORS 441.092, OL 2013, ch. 552

RULE SUMMARY

The Oregon Health Authority (Authority), Public Health Division temporarily amended OAR 333-072-0215 on July 28, 2014 pertaining to requirements for notification of patient choice. By temporarily amending OAR 333-072-0215, the agency is able to reconsider the requirement to provide notification of patient choice every time a referral is made outside of an emergency department or in-patient setting. Additionally, this temporary amendment allows the Authority ample time to convene another Rules Advisory Committee to revisit the notification requirements.

After further review, it was noticed that the language in regards to how the notice was given, was not clear. The Authority is filing OAR 333 -072-0215 again in order to add in "or oral" under OAR 333-072-0215(3). The expiration of these temporary rules will remain the same.

Brittany Sande — brittany.a.sande@state.or.us

Rules Coordinator Name — Email Address

Secretary of State

NOTICE OF PROPOSED RULEMAKING HEARING*

A Statement of Need and Fiscal Impact accompanies this form

FILED
11-14-14 11:34 AM
ARCHIVES DIVISION
SECRETARY OF STATE

Oregon Health Authority, Public Health Division — 333
Agency and Division — Administrative Rules Chapter Number

Brittany Sande — (971) 673-1291
Rules Coordinator — Telephone

Oregon Health Authority, Public Health Division, 800 NE Oregon St., Suite 930, Portland, OR 97232
Address

RULE CAPTION

Patient notification of choice by practitioners as required by the passage of SB 683 (2013)

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

Hearing Date	Time	Location	Hearings Officer
12-16-14	1:00 p.m.	Portland State Office Building; 800 NE Oregon St. Rm 618; Portland, OR	Jana Fussell

RULEMAKING ACTION

Secure approval of rule numbers with the Administrative Rules Unit prior to filing.

ADOPT:

AMEND:
333-072-0215

REPEAL:
333-072-0215(T)

RENUMBER: Secure approval of new rule numbers with the Administrative Rules Unit prior to filing.

AMEND AND RENUMBER: Secure approval of new rule numbers with the Administrative Rules Unit prior to filing.

Statutory Authority:
ORS 441.098

Other Authority:
OL 2013, ch. 552

Statutes Implemented:
ORS 441.098

RULE SUMMARY

The Oregon Health Authority, Public Health Division is proposing to amend this rule relating to notice of patient choice in response to the passage of SB 683 during the 2013 legislative session.

The Authority needs to amend this rule to set forth the form and manner for health practitioners to provide notice of patient choice related to referrals for diagnostic tests, health care services or treatment.

The proposed rule provides for written or oral notice of patient choice at the time the patient establishes care and that notice must also be posted in a conspicuous place. The rule sets forth the information that must be provided. When health practitioners choose to provide notice at the time of referral, the rule sets forth the information that the practitioner must provide. Practitioners must document all oral notices. Implementation of this rule will ensure that health care consumers are aware of their right to choose care providers.

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

12-22-2014 5:00 p.m. — Brittany Sande — brittany.a.sande@state.or.us

Secretary of State

STATEMENT OF NEED AND FISCAL IMPACT

A Notice of Proposed Rulemaking Hearing accompanies this form.

FILED
11-14-14 11:34 AM
ARCHIVES DIVISION
SECRETARY OF STATE

Oregon Health Authority, Public Health Division — 333
Agency and Division — Administrative Rules Chapter Number

Patient notification of choice by practitioners as required by the passage of SB 683 (2013)

Rule Caption (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of:

Amendment of OAR 333-072-0215

Statutory Authority:
ORS 441.098

Other Authority:
OL 2013, ch. 552

Statutes Implemented:
ORS 441.098

Need for the Rule(s):
The Oregon Health Authority, Public Health Division is proposing to amend this rule relating to notice of patient choice in response to the passage of SB 683 during the 2013 legislative session.

The Authority needs to amend this rule to set forth the form and manner for health practitioners to provide notice of patient choice related to referrals for diagnostic tests, health care services or treatment.

The proposed rule provides for written or oral notice of patient choice at the time the patient establishes care and that notice must also be posted in a conspicuous place. The rule sets forth the information that must be provided. When health practitioners choose to provide notice at the time of referral, the rule sets forth the information that the practitioner must provide. Practitioners must document all oral notices.

Implementation of this rule will ensure that health care consumers are aware of their right to choose care providers.

Documents Relied Upon, and where they are available:
ORS 441.098: https://www.oregonlegislature.gov/bills_laws/lawsstatutes/2011ors441.html
SB 683 (2013): https://olis.leg.state.or.us/liz/2013R1/Measures/Text/SB683/Enrolled

Fiscal and Economic Impact:
There will be a minimal fiscal impact to the Authority's Health Licensing Office and other licensing Boards responsible for enforcing this rule.

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)):
Aside from the minimal fiscal impact to the Authority's Health Licensing Office and other licensing Boards described above, there is no additional cost of compliance anticipated.

There is no known cost of compliance impact on any other state agencies, units of local government or the general public.

2. Cost of compliance effect on small business (ORS 183.336):

a. Estimate the number of small business and types of businesses and industries with small businesses subject to the rule:
The Authority is unable to estimate the number of health practitioner's offices which qualify as a small business as defined in ORS 183.400 (10) with 50 or fewer employees. All health practitioners are subject to the requirements of this rule.

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services:
Health practitioners will incur an initial cost to create a new form, new posted notice or to adapt current forms and adopt policies and procedures to comply with the rule. Integration into current practices may involve some costs for training and maintaining documentation of patient notification in practitioner records. There may also be costs associated with changes to an electronic medical record, which will vary

depending on whether the health practitioner chooses to provide notice at the time of referral. Practitioners providing oral notice may incur costs related to documentation of the notice. The Authority is unable to estimate the actual costs, as they will vary for each practice, depending on size or number of clinics.

c. Equipment, supplies, labor and increased administration required for compliance:
Practitioners may incur costs related to record keeping and supplies to comply with the notice requirements. However, these costs are anticipated to be minimal.

How were small businesses involved in the development of this rule?
A Rules Advisory Committee (RAC) was established and included representatives from Oregon Medical Association (OMA), which represents small health practices and clinics. Membership also included Epic Imaging and Chehalem Physical Therapy Inc. and a representative for Oregon Physical Therapists in Independent Practice (OPTIP).

Administrative Rule Advisory Committee consulted?: Yes
If not, why?:

12-22-2014 5:00 p.m.	Brittany Sande	brittany.a.sande@state.or.us
Last Day (m/d/yyyy) and Time for public comment	Printed Name	Email Address

Underlined text is being added. ~~Strikethrough text~~ is being deleted.

OREGON ADMINISTRATIVE RULES
OREGON HEALTH AUTHORITY, PUBLIC HEALTH DIVISION
CHAPTER 333

DIVISION 72

HEALTH CARE PRACTITIONER REFERRALS

333-072-0215
Requirements for Notification of Patient Choice

(1) A referral for a diagnostic test or health care treatment or service shall be based on the patient's clinical needs and personal health choices.

(2) A health practitioner may~~shall~~ not deny, limit or withdraw a referral solely because the patient chooses to have the diagnostic test or health care treatment or service at a facility other than the one recommended by the health practitioner.

(3) A health practitioner or the practitioner's designee shall provide written or oral notice of patient choice at the time the patient establishes care with the practitioner~~. and at the time the referral is communicated to the patient~~ The notice shall include the following:~~.~~

(a) The patient has a choice and when referred to a facility for a diagnostic test or health care treatment or service the patient may receive the diagnostic test or health care treatment or service at a facility other than the one recommended by the health practitioner;

(b) If the patient chooses to have the diagnostic test, health care treatment or service at a facility different from the one recommended by a practitioner, the patient is responsible for determining the extent or limitation of coverage for the diagnostic test, health care treatment or service at the facility chosen by the patient.

(c) A health practitioner may not deny, limit or withdraw a referral solely because the patient chooses to have the diagnostic test or health care treatment or service at a facility other than the one recommended by the health practitioner.

~~(a) Notice may be provided either orally or in writing.~~

~~(b) If a referral is provided to a patient electronically or telephonically and the patient does not present for treatment in person or is not present at the time of the referral, the health practitioner or the practitioner's designee shall provide either written or oral notice to the patient at the same time the referral is communicated to the patient.~~

(4) Health practitioners shall also post notice of patient choice in a conspicuous place. The posted notice shall include the information set forth in subsection (3)(a) and (b) of this rule.

(5) At the time of referral health practitioners may provide written or oral notice of patient choice. The notice shall include the information set forth in subsection (3)(a) of this rule.

(6) Practitioners must document all oral notifications.

~~(4) The oral notice of patient choice shall clearly inform the patient:~~

~~(a) That when referred, a patient has a choice about where to receive services; and~~

~~(b) Where the patient can access more information about patient choice.~~

~~(5) The written notice of patient choice shall include language that clearly informs the patient that:~~

~~(a) The patient has a choice and when referred to a facility for a diagnostic test or health care treatment or service the patient may receive the diagnostic test or health care treatment or service at a facility other than the one recommended by the health practitioner;~~
~~(b) If the patient chooses to have the diagnostic test, health care treatment or service at a facility different from the one recommended by a practitioner, the patient is responsible for determining the extent of coverage or the limitation on coverage for the diagnostic test, health care treatment or service at the facility chosen by the patient.~~
~~(c) A health practitioner shall not deny, limit or withdraw a referral solely because the patient chooses to have the diagnostic test or health care treatment or service at a facility other than the one recommended by the health practitioner.~~
~~(6) In addition to providing notice of patient choice at the time the patient establishes care with the practitioner and at the time the referral is communicated to the patient, practitioners shall post notice in a conspicuous location.~~
~~(a) The notice shall include at minimum:~~
~~(A) Information that notifies patients that they have a choice about where to receive diagnostic testing, healthcare treatment and services.~~
~~(B) Direction to talk to a provider about their choices when a referral is made.~~
~~(C) Where to get additional information.~~
~~(b) Posted notice does not replace either the written or oral notice required by section (3) of this rule.~~

Stat. Auth.: ORS 441.098
Stats. Implemented: ORS 441.09~~8~~2~~, OL 2013, ch. 552~~

Public Health Division

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Center for Health Statistics

Office of Equity & Inclusion

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Cultural Competency Committee

CHARTER - Cultural Competence Continuing Education Curriculum Approval Committee

Authority

House Bill (HB) 2611 (2013), allows health care professional boards to adopt rules which may require a person authorized to practice the profession, regulated by the "board", to receive cultural competency continuing education approved by the Oregon Health Authority. HB2611 requires the Oregon Health Authority (OHA) to provide resources and support for improving the cultural competency of regulated health care professionals in Oregon, and to report to the Oregon State Legislature about the level of participation among regulated health care professionals.

The Authority shall approve continuing education opportunities relating to cultural competency and develop a list of continuing education opportunities related to cultural competency and make the list available to each board specified in the legislation.

Background: Cultural Competence Continuing Education

Oregon Health Authority, Office of Equity and Inclusion (OEI) established the Cultural Competence Continuing Education Committee (CCCEC) from April-Dec 2012, to explore opportunities to promote cultural competence continuing education for health care professionals. Membership was comprised of a group of 23 professionally and culturally diverse stakeholders including representatives from: health licensing boards, professional associations, health systems organizations, providers, community based organizations, and small business. Final report and recommendations are available on the OEI website.

Scope

The Cultural Competency Continuing Education Curriculum Approval Committee will be responsible for:

1) Advising OHA on the development of a **process** to approve a list of cultural competency continuing education opportunities,
2) Advising OHA on the development of **criteria** to approve cultural competency continuing education opportunities for the OHA list, and
3) Working with OHA to **implement the process**

Membership, Roles & Responsibilities

Executive Sponsor: Leann Johnson, Interim Director, OEI
Staff: Carol Cheney, OEI
Emily Wang, OEI

CCCE Curriculum Approval Committee Members

Amela Blekic, Oregon Health & Science University-Department of Psychiatry
Sandra Clark, Health Share of Oregon
Jordan Ferris, Oregon Nurses Association
Antonio Flores, Planned Parenthood of Southwestern Oregon
Benjamin Gerritz, Cascade AIDS Project
Maileen Hamto, Oregon Health & Science University-Center for Diversity & Inclusion
Leslie Houston, Oregon Home Care Commission
Fiona Karbowicz, Oregon Board of Pharmacy
Sunil Khanna, Oregon State University-College of Public Health and Human Services
Shafia Monroe, International Center for Traditional Childbearing
Nancy Nolin, Quest Center for Integrative Health
Samie Patnode, Oregon Health Authority-Health Licensing Office
Susan Polvi, Linn County Mental Health Services, Quality Improvement
Jorge Ramirez, Oregon Research Institute
Joseph, Santos-Lyons, Oregon Health Equity Alliance/Asian Pacific American Network of Oregon
Kimberly Tippens, Helfgott Research Institute, National College of Natural Medicine
Lucy Zammarelli, Trillium Behavioral Health

TIMELINE
Curriculum Approval Committee Timeline o HB2611 Effective Date – Jan 1, 2015 o First Curriculum Approval Committee Meeting- February 4, 2015, 2-4 p.m. o Subsequent committee meetings-monthly first, then bi-monthly/quarterly/semi-annually?

AGENDA
Cultural Competence Continuing Education Curriculum Approval Committee
Feb 4th, 2015 · 2:00-4:00 p.m.
Oregon Health Authority-Lincoln Building-OEI Conference Room
421 SW Oak St., Ste. 750 · Portland, OR 97204

#	Time	**Item** (related materials)	Presenter(s)
1	2:00	Introductions & Agenda Review • Introducing Leann Johnson, Interim OEI Director	Carol Cheney
2	2:15	Background/History • Cultural Competence Continuing Education Committee Report • HB2611 Final Rules	Emily Wang
3	2:35	Discussion: Proposed committee charter • Develop criteria for approving curriculum • Develop process for approving curriculum for OHA list • Implement the process	Emily
4	3:05	Public Comment	Members of the Public
5	3:20	Discussion: Next meeting agenda • Any homework, subcommittee needs?	All
6	3:35	Proposed 2015 meeting schedule • Monthly/bi-monthly, then quarterly?	All
7	3:45	Check-in: Today's meeting/committee name change?	All
8	4:00	Adjourn	

The Oregon Health Authority Office of Equity and Inclusion (OEI) strives to ensure the comfort and safety of staff and visitors by requiring a smoke free environment and encouraging a fragrance free environment.
If you have a disability and need a modification to attend or fully participate in this event, please contact: Emily Wang at 971-673-2307. This request is included in notices for board meetings, hearings, public events and all other meetings sponsored or hosted by the OHA Office of Equity and Inclusion. Thank you for your cooperation.

OREGON HEALTH AUTHORITY, OFFICE OF EQUITY AND INCLUSION

DIVISION 943

CULTURAL COMPETENCY CONTINUING EDUCATION FOR HEALTH CARE PROFESSIONALS

943-090-0000
Purpose
These rules create requirements for the Oregon Health Authority to provide resources and support for improving the cultural competence of regulated health care professionals in Oregon and to report to the Oregon State Legislature as required by 2013 Oregon Law, Chapter 240 about the level of participation in cultural competence education among regulated health-care professionals.
Stat. Auth.: ORS 413.042, 2013 Oregon Law, Chapter 240

943-090-0010

Definitions
The following definitions apply to OAR 943-090-0000 through 943-090-0020:
(1) “Authority” means the Oregon Health Authority.
(2) “Continuing Education” means a unit or units of education as defined by each board to which this statute is applicable.
(3) “Cultural competence” means a life-long process of examining values and beliefs and developing and applying an inclusive approach to health care practice in a manner that recognizes the context and complexities of provider-patient communication and interaction and preserves the dignity of individuals, families and communities.
(a) Cultural competence applies to all patients.
(b) Culturally competent providers do not make assumptions on the basis of an individual’s actual or perceived abilities, disabilities or traits whether inherent, genetic or developmental including: race, color, spiritual beliefs, creed, age, tribal affiliation, national origin, immigration or refugee status, marital status, socio-economic status, veteran’s status, sexual orientation, gender identity, gender expression, gender transition status, level of formal education, physical or mental disability, medical condition or any consideration recognized under federal, state and local law.
(4) “Patient” represents individuals in the broadest spectrum of the roles in health and home care services, including but not limited to: patient, consumer, client, patient representative, resident, and patient family or community.
(5) “Provider” represents individuals in the broadest spectrum of roles in health and home care services, including but not limited to: physicians, nurses, social workers, medical technicians, traditional health workers, and home care and personal support workers.

Stat. Auth.: ORS 413.042, 2013 Oregon Law, Chapter 240

943-090-0020

Cultural Competence Resources, Support and Reporting

(1) The Authority, through its Office of Equity and Inclusion, shall create, maintain and make available a list of approved continuing education opportunities for developing cultural competence for regulated health care professionals.
(2) The Authority shall collaborate with legislatively designated boards to:
(a) Create model rule language for affected boards to document cultural competence continuing education.
(b) Create a reporting structure for affected boards to report on the cultural competence continuing education completed by regulated health care professionals.
(3) The Authority shall establish an advisory committee to:
(a) Develop or update criteria for approving cultural competence continuing education opportunities.
(b) Discuss and recommend cultural competence continuing education opportunities to the Authority for approval.
(4) The advisory committee shall include members of communities that experience health disparities because of race, ethnicity or culture.
(5) The Authority shall base the list of approved opportunities for cultural competence continuing education on the criteria established by the advisory committee.
(6) Authority approved continuing education opportunities shall teach attitudes, knowledge and skills enabling health care professionals to effectively communicate with and care for patients from diverse cultures, groups, and communities.
(a) These skills may include:
(A) Applying linguistic skills to communicate effectively with patients.
(B) Using cultural information to establish therapeutic relationships.
(C) Eliciting, understanding and applying cultural and ethnic data in the process of clinical care.
(b) Authority approved continuing education opportunities may include:
(A) Courses delivered in-person or electronically.
(B) Experiential learning such as cultural or linguistic immersion.
(C) Service learning.
(D) Specially designed cultural experiences.
(7) The affected boards shall report to the Authority no later than 30 days after the close of each biennium regarding:
(a) Regulated health care professionals who completed cultural competence continuing education.
(b) Audited health care professionals who completed cultural competence continuing education from the Authority approved list.
(c) Whether the board requires members participate in cultural competence continuing education.
(d) The level of reporting each board requires of members related to participation in cultural competence continuing education.
(8) The Authority shall compile a biennial report on the participation of health care professionals in cultural competence continuing education, including the number of:
(a) Regulated health care professionals who completed cultural competence continuing education.
(b) Audited health care professionals who completed cultural competence continuing education from the Authority approved list.
(c) The number of boards requiring that members participate in cultural competence continuing education.

(d) The level of reporting each board requires of members related to participation in cultural competence continuing education.
(9) On or before August 1 of each even-numbered year, the Authority shall report to the interim committees of the Legislative Assembly, including those related to health care, audits, information management, and information technology about the participation of health-care professionals in cultural competence continuing education as submitted to the Authority by the boards.

Stat. Auth.: ORS 413.042, 2013 Oregon Law, Chapter 240

Regulatory Report

Health Licensing Office

700 Summer St. NE, Suite 320
Salem, OR 97301-1287
Phone: (503) 378-8667
Fax: (503) 370-9004
Web: www.oregon.gov/oha/hlo
E-mail: hlo.info@state.or.us

Board of Direct Entry Midwifery

February 12, 2015

2009 – 2011 Biennium Follow Up

Between July 1, 2009 and June 30, 2011, 41 complaints were received. Total open 7. Total closed 34.

Allegation Filed By:		
Mandatory Reporter	**Client**	**Other**
22	**16**	**3**

2011 – 2013 Biennium

Between July 1, 2011 and June 30, 2013, 28 complaints were received. Total open 12. Total closed 16.

Allegation Filed By:		
Mandatory Reporter	**Client**	**Other**
14	**9**	**5**

2013 – 2015 Biennium

Between July 1, 2013 and December 31, 2014, 13 complaints were received. Total open 10. Total closed 3.

Allegation Filed By:		
Mandatory Reporter	**Client**	**Other**
10	**0**	**3**

Interested Parties Feedback

From: Jesica Dolin [mailto:jesicadolin@yahoo.com]
Sent: Friday, January 09, 2015 2:15 PM
To: Patnode Samie
Cc: Omc VicePresident; OMClegislativeliaison; Colleen Forbes
Subject: Official Request from OMC

Hi Samie! Could you please put this topic on the agenda for the February 12th board meeting, and have this letter read out loud at that mtg?

OMC recognizes that OHLA and the midwifery board have made great changes in the way that they operate and conduct themselves. However, there remains some residual fear/lack of understanding in the midwifery community regarding how the board works and how investigations are conducted. Additionally, the recent change to mandatory licensing has created a resurgence of questions from members about how investigation functions.

We would love for there to be a presentation from OHLA/our board at our statewide meeting regarding what it means for practical purposes to have an autonomous board, and what the new investigations process looks like. Ideally, a member of the board and a member of OHLA (perhaps even an investigator?) could co-present, but we are open to whatever would work best.

The meeting that we were hoping for this presentation to be ready for is Friday, May 15th, at 10am in Eugene. Ideally, your presentation would be the start of the day as our CEU opportunity. If we need to move this meeting to Salem in order to make this happen, that is an option on the table.

Thanks!

Jesica Dolin, BSM, CPM, LDM
Communications Coordinator
Oregon Midwifery Council

From: Silke Akerson [mailto:silkeakerson@gmail.com]
Sent: Friday, February 06, 2015 9:16 AM
To: Patnode Samie
Cc: Mercer Holly
Subject: Letter to BDEM re: final orders

Good morning Samie,
Can you forward this letter, on a recent final orders, to the members of the Board of Direct Entry Midwifery? Thank you. Silke Akerson

Dear Members of the Board of Direct Entry Midwifery,

I am writing on behalf of the Oregon Midwifery Council to express my gratitude for your service on the Board and your care in dealing with complaints and investigations as well as to express a concern about a specific case that has come to our attention.

Our understanding is that the Board of Direct Entry Midwifery, along with many other healthcare boards, seeks to improve outcomes and the quality of patient care through education and supervision as the primary outcomes of investigations where issues are found in cases that do not involve willful endangerment of patients. The Oregon Midwifery Council fully supports a regulatory process that identifies concerns and seeks to correct them through appropriate education and supervision and that reserves suspension or revocation of licenses to cases where the public is endangered by the practice of the midwife in question.

For this reason, we were concerned to learn that the final orders in the case of Pamela Echevario include a 3 year suspension of her license and a $5000 fine. We recognize that corrective action may be needed in this case, but we are dismayed and confused at the severity of the final orders in a case in which the family reports that they received excellent care and the actions of the midwife did not result in harm to mother or baby. We are aware that there are also charting issues in this case our understanding is that they represent mistakes not the willful deception that would warrant a license suspension. We realize that we may not have all of the information available on this case and that our perspective may be limited by that.

We hope that you will consider the precedent that this case may set before the hearing next week. We request that you each ask yourself some questions about this case and investigations in general. How are these final orders consistent with the intention of the Board? When such severe consequences are given in this case how will you set a consistent standard for consequences and how will you differentiate this case from other, more extreme cases that need major action short of license revocation? We recognize that you are charged with a difficult task and appreciate the time and care that you put into considering each and every case.

Thank you for your consideration,

Silke Akerson, CPM, LDM
Oregon Midwifery Council

Executive Session

♦ ♦

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

Regulatory Items for Board Action

Other Board Business

Oregon Health Authority

Health Licensing Office
Board of Direct Entry Midwifery
February 12, 2015

****PLEASE PRINT****

Name (First, Last)	Representing	Request to Comment (yes/no)
Danielle Sobel	OMA	NO
Sharron Fuchs	self	?
Kimberly Kincade	OMC VP	?
Mandy Vleisch	staff	NO