HEALTH LICENSING OFFICE

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Date: **August 29, 2019**

To: **Interested Parties**

From: **Samantha Patnode, Policy Analyst**

Subject: **Proposed Administrative Rules – Direct Entry Midwifery**

The Board of Direct Entry Midwifery filed Notice of Rulemaking for publication in the September 2019 Oregon Bulletin. Copies of the filing paperwork and rule text are available at https://www.oregon.gov/OHA/PH/HLO/Pages/Board-Direct-Entry-Midwifery-Laws-Rules.aspx.

Comments on the proposed rules will be taken from September 1 through September 28, 2019 at 5 pm. Comments received before September 1 will not be accepted.

Please send comments to:
Samie Patnode, Policy Analyst
1430 Tandem Ave., Suite 180,
Salem, OR 97301
samie.patnode@state.or.us

A public hearing will not be held.

For alternative formats please contact me at the number or email below.
If you have any questions or need additional information, please contact me at (503) 373-1917 or samie.patnode@state.or.us.

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DEPUTY SECRETARY OF STATE

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800 SUMMER STREET NE
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NOTICE OF PROPOSED RULEMAKING

INCLUDING STATEMENT OF NEED & FISCAL IMPACT

FILED
08/02/2019 8:49 AM
ARCHIVES DIVISION
SECRETARY OF STATE

CHAPTER 332
OREGON HEALTH AUTHORITY
HEALTH LICENSING OFFICE, BOARD OF DIRECT ENTRY MIDWIFERY

FILING CAPTION: Substantial changes to proposed rules based on public comment - risk and termination of care.

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 09/28/2019 5:00 PM

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.

A public rulemaking hearing may be requested in writing by 10 or more people, or by a group with 10 or more members, within 21 days following the publication of the Notice of Proposed Rulemaking in the Oregon Bulletin or 28 days from the date the Notice was sent to people on the agency mailing list, whichever is later. If sufficient hearing requests are received, the notice of the date and time of the rulemaking hearing must be published in the Oregon Bulletin at least 14 days before the hearing.

CONTACT: Samantha Patnode
503-373-1917
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Filed By:
Anne Thompson
Rules Coordinator

NEED FOR THE RULE(S):

The rule amendments are necessary to align current rules with midwifery industry standards. Revisions are also needed to streamline current requirements and clarify complex processes.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

Public comment received from April 1 through June 4, 2019. Hearing officer report from April 17 and April 24, 2019. Administrative rule schedule and resource/reference list, including resources utilized after public comment was received. All documents are available at the Health Licensing Office, 1430 Tandem Ave Suite 180, Salem, OR 97301-1287. To obtain information or copies of information please contact Samantha Patnode, Policy Analyst, at 503-373-1917.

FISCAL AND ECONOMIC IMPACT:

The fiscal and economic impact is generally indeterminate based risk, transfer of care, indication to consult and termination of care. Specific information is listed under cost of compliance.

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

The state agency likely to be affected is the Oregon Health Authority through the Oregon Health Plan (OHP). Out of hospital birth is currently covered under the Fee for Service - Prior Authorization Guidelines of the OHP. The cost for a home birth through OHP is approximately $2600 whereas the cost of a hospital birth is much higher. These estimates

only include fees for the facility and professional cost not for other costs such as anesthesia. The approximate time it takes an OHA staff member to review and approve a prior authorization for an out of hospital birth is 4.5 hours at a rate of $60 totaling $265. For a home birth OHP fee-for service pays approximately:
$2,340 Global maternity care fee (prenatal care, birth, immediate postpartum care)
$ 229 Supplies (the medications and supplies we bring to a birth)
$ 145 Assist fee (the amount OHP pays for a second midwife)
$ 64 Newborn exam
Total $2,778. Rule amendments require more consultation for certain indications. If licensed direct entry midwifes (LDM) are considered the public there may be fees associated with consulting other providers who have expertise with the indication. Consultation may happen in person, by telephone or other means available. The cost for consulting may vary by type, provider, length of consult, insurance coverage, etc. and is not quantifiable. This also may affect LDMs if the consulting provider recommends transfer of care to another provider and transfer occurs, costing LDMs approximately $2600 for care for the entire pregnancy including postpartum and newborn care. Consumers may also be affected by consultation fees depending on how charges are quantified, if any, and passed on to clients.

If a consumer must transfer care to hospital from a home birth with a licensed direct entry midwife it will likely be an increased cost, to that consumer depending on insurance coverage, deductibles and copayments. It costs an estimated $30,000 for a vaginal delivery and $50,000 for a Cesarean section in which commercial insurers pay out an average of $18,000 and $28,000. Costs include but are not limited to medications, hospital costs, doctors' fees, newborn care, blood work, surgery supplies and labor room.

Exact costs are not quantifiable because of the variable involved – consumer choice, various health plans/copays, various times at which care may be transferred which would impact the length of prenatal care with a provider or possibly emergency care received, whether a specialist (maternal/fetal medicine) is needed or an OBGYN, whether additional pregnancy or labor conditions would surface or be avoided due to a change in care to a doctor, hospital, or traditional midwife, whether LDM supportive care is provided, etc.

Assuming a traditional midwife is considered the public, a mother could transfer care to a traditional midwife; there is no regulatory oversight of traditional midwives in Oregon, except for the client disclosures they must provide, and traditional midwives are prohibited from using legend drugs and devices. Thus, a transfer of care could financially benefit a traditional midwife. The cost for a traditional midwife will likely be less than hospital birth. The cost for a traditional midwife assisted birth is unknown.
(2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

If a mother chooses to transfer care to a traditional midwife, the traditional midwife is likely a small business owner with a small practice and client base, then the traditional midwife would likely see a positive impact. The cost for a traditional midwife is unknown so the fiscal impact cannot be determined.

Generally, LDMs are sole proprietors with small businesses in the practice of midwifery. There are approximately 80

LDMs in Oregon. If indications arise that require transfer of care, including twins and postdates (past 43 weeks) pregnancies, whether to a traditional midwife, emergency services or a hospital, the small business may see a negative impact. Cost for total pregnancy is approximately $2600 depending on insurance, fee for service payments by Oregon Health Plan or private consumer payments. If the LDM provides supportive care to the client following the transfer of clinical care, then the impact on the small business would likely be less.

LDMs usually work or own small businesses, where consulting is required, there may be charges made to the small business as discussed above. These costs are not quantifiable and would depend on the type of consultation, provider, length of consult, insurance coverage, etc..

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

There are seven members on the Board of Direct Entry Midwifery some of which are small business owners who helped develop the proposed rules. The Oregon Midwifery Council was also involved in the proposed rule review which is made up of many small business owners. The Rules Advisory Committee was made up of small business owners. Public comment was received from April 1 through June 4, which may have been from small business owners, and was used to develop the amendments to the rules.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:
332-025-0021, 332-025-0130

AMEND: 332-025-0021

RULE SUMMARY: Risk assessment criteria has been amended to specify when a transfer of care must be completed, measures for resolution and risk assessment. Changes in indications include but are not limited to the following:

Indication to transfer - preexisting and historical conditions:
Clarify diabetes currently requiring oral medication or insulin.

Indication to transfer - intrapartum:
Add retained placenta; and
Add significant hemorrhage unresponsive to treatment with or without sustained vital sign instability or shock.

Indication to transfer - postpartum:
Remove retained placenta; and
Add signs and symptoms of uterine infection.

Indication to transfer - newborn:

Clarify jaundice at birth or in the first 24 hours.

Indication to consult - preexisting and historical conditions:
Clarify current treatment with prescription medication for any ongoing or chronic medical conditions;
Clarify deep venous thrombosis or any treated thromboembolic event; and
Clarify placental abruption with adverse outcomes.

Indication for consult - antepartum:
Clarify thromboembolic event.

Indication for consult - postpartum:
Clarify evident or suspected infection unresponsive to treatment.

indication for consult - newborn:
Clarify weight loss greater than 10 percent of birth weight that does not respond to treatment;
Clarify Direct Coomb's positive. Consultation for Direct Coomb's positive newborns must be with a pediatric care provider;
Clarify newborn with Human Immunodeficiency Virus (HIV)-positive mother. Consultation for a newborn with Human Immunodeficiency Virus (HIV)-positive mother must be with a pediatric care provider;
Clarify evident or suspected neonatal opioid withdrawal syndrome;
Add respiration rate greater than 100 within the first two (2) hours postpartum, and greater than 80 thereafter, lasting more than one (1) hour without improvement; and
Add evident or suspected abnormally elevated bilirubin

CHANGES TO RULE:

332-025-0021
Risk Assessment Practice Standards ¶

~~Licensees must assess the appropriateness of an out-of-hospital birth taking into account the health and condition of the mother and baby according to the following absolute and non-absolute risk criteria:¶~~
~~(1) "Absolute risk" as used in this rule means conditions or clinical situations of obstetrical or neonatal risk that cannot be resolved and that preclude out-of-hospital care. If the mother or baby presents with any absolute risk factors, the LDM must:¶~~
~~(a) During the antepartum period, plan for transfer of care and an in-hospital birth;¶~~
~~(b) During the intrapartum period, arrange transportation to the hospital and transfer of care unless the birth is imminent;¶~~
~~(c) When the birth is imminent, take the health and condition of the mother and baby and conditions for transport~~

into consideration in determining whether to proceed with out-of-hospital birth or to arrange for transportation to a hospital and transfer of care;¶
(d) During the postpartum period, arrange for transportation of mother or baby to a hospital and transfer of care;¶
(2) The following constitute absolute risk factors:¶
(a) ANTEPARTUM ABSOLUTE RISK CRITERIA:¶
(A) Active cancer;¶
(B) Cardiac condition with hemodynamic consequences;¶
(C) Severe renal disease - active or chronic;¶
(D) Severe liver disease - active or chronic;¶
(E) Uncontrolled hyperthyroidism;¶
(F) Chronic obstructive pulmonary disease;¶
(G) Essential chronic hypertension over 140/90;¶
(H) Pre-eclampsia/eclampsia;¶
(I) Current venous thromboembolic disease;¶
(J) Current substance abuse known to cause adverse effects for the mother or baby;¶
(K) Incomplete spontaneous abortion;¶
(L) Hemoglobin under nine at term;¶
(M) Placental abruption;¶
(N) Placenta less than 2.0 centimeters from internal os at onset of labor;¶
(O) Persistently or severely abnormal quantity of amniotic fluid;¶
(P) Signs and symptoms of chorioamnionitis;¶
(Q) Ectopic pregnancy;¶
(R) Pregnancy lasting longer than 43 weeks gestation (21 days past the due date);¶
(S) Any pregnancy with abnormal fetal surveillance tests;¶
(T) Active acquired immune deficiency syndrome (AIDS);¶
(U) Higher order multiples (three or more);¶
(V) Monochorionic, monoamniotic twins;¶
(W) Twin-to-twin transfusion;¶
(X) Presenting twin transverse;¶
(Y) Three cesarean sections unless previous successful vaginal birth;¶
(Z) Placenta accreta, percreta or increta;¶
(AA) Non-cephalic presentation except as noted in non-absolute risk criteria;¶
(BB) Previous classical uterine incision, T-incision, prior uterine rupture or extensive transfundal surgery;¶
(CC) Four or more cesarean sections; and¶
(DD) Pre-existing diabetes requiring oral medication or insulin.¶
(b) INTRAPARTUM ABSOLUTE RISK CRITERIA:¶
(A) Documented intrauterine growth restriction at term;¶
(B) Evident or suspected uterine rupture;¶
(C) Prolapsed cord or cord presentation;¶
(D) Evident or suspected complete or partial placental abruption;¶
(E) Evident or suspected placenta previa;¶
(F) Evident or suspected chorioamnionitis;¶
(G) Pre-eclampsia/eclampsia;¶
(H) Thick meconium-stained amniotic fluid without reassuring fetal heart tones and birth is not imminent;¶
(I) Evidence of fetal distress or abnormal fetal heart rate pattern unresponsive to treatment or inability to auscultate fetal heart tones;¶
(J) Excessive vomiting, dehydration, acidosis or exhaustion unresponsive to treatment;¶
(K) Blood pressure greater than or equal to 150/100 which persists or rises, and birth is not imminent;¶

(L) Labor or premature rupture of membrane less than 35 weeks according to estimated due date;¶
(M) Current substance abuse known to cause adverse effects for the mother or baby;¶
(N) Retained placenta with suspected placenta accreta;¶
(O) Active herpes lesion in an unprotectable area;¶
(P) Primary herpes outbreak in labor; and¶
(Q) Evident or suspected footling or kneeling breech.¶
(c) MATERNAL POSTPARTUM ABSOLUTE RISK CRITERIA:¶
(A) Retained placenta with suspected placenta accreta;¶
(B) Retained placenta with abnormal or significant bleeding;¶
(C) Laceration requiring referral of care for repair including but not limited to third and fourth-degree lacerations;¶
(D) Uncontrolled postpartum bleeding;¶
(E) Increasingly painful or enlarging hematoma;¶
(F) Development of pre-eclampsia; and¶
(G) Signs or symptoms of shock unresponsive to treatment.¶
(d) INFANT ABSOLUTE RISK CRITERIA:¶
(A) Apgar less than 7 at 10 minutes of age;¶
(B) Respiration rate greater than 100 within the first two hours postpartum, and greater than 80 thereafter, lasting more than one hour without improvement;¶
(C) Persistent nasal flaring, grunting, or retraction after one hour of life without improvement;¶
(D) Seizures;¶
(E) Apnea;¶
(F) Central cyanosis;¶
(G) Large or distended abdomen;¶
(H) Any condition requiring more than 12 hours of observation postbirth;¶
(I) Persistent poor suck, hypotonia or a weak or high-pitched cry;¶
(J) Persistent inability to maintain temperature between 97-100 degrees Fahrenheit;¶
(K) Persistent projectile vomiting or emesis of fresh blood; and¶
(L) Signs and symptoms of infection in the infant.¶
(3) "Non-absolute" means a condition or clinical situation that places a mother or baby at increased obstetric or neonatal risk, but does not automatically exclude a mother and baby from an out-of-hospital birth.¶
(4) When a mother or baby presents with one or more non-absolute risk factors, the LDM must:¶
(a) Arrange for the transfer of care of the mother or baby; or¶
(b) Comply with all of the following:¶
(A) Consult with at least one Oregon licensed health care provider regarding the non-absolute risk factors present.¶
(B) Discuss the non-absolute risk(s) with the mother, including:¶
(i) Possible adverse outcomes;¶
(ii) Whether an out-of-hospital birth is a reasonably safe option based upon the risk(s) present;¶
(iii) The anticipated risk(s) and the likelihood of reducing or eliminating said risks;¶
(iv) The midwife's experience with said risk(s);¶
(v) The ease and time involved in accomplishing transport or transfer of care;¶
(vi) Recommendation(s) given by the consulting Oregon licensed health care provider(s); and¶
(vii) Recommendation(s) given by the LDM to the mother.¶
(C) Document discussion of information listed in subsection (B).¶
(D) To the extent the LDM acts contrary to the recommendations given by the consulting Oregon licensed health care provider, the LDM must document the justification.¶
(E) Informed consent must be obtained and documented in records.¶
(5) The following are non-absolute risk factors:¶

~~(a) MATERNAL ANTEPARTUM NON-ABSOLUTE RISK CRITERIA:¶~~
~~(A) Conditions that could negatively affect maternal or fetal status that require ongoing medical supervision or ongoing use of medications;¶~~
~~(B) Inappropriate fetal size for gestation;¶~~
~~(C) Significant second or third trimester bleeding;¶~~
~~(D) Abnormal fetal cardiac rate or rhythm;¶~~
~~(E) Decreased fetal movement;¶~~
~~(F) Uterine anomaly;¶~~
~~(G) Anemia (hematocrit less than 30 or hemoglobin less than 10 at term);¶~~
~~(H) Seizure disorder requiring prescriptive medication;¶~~
~~(I) Platelet count of less than 75,000;¶~~
~~(J) Isoimmunization to blood factors;¶~~
~~(K) Psychiatric disorders;¶~~
~~(L) History of thrombophlebitis and hemoglobinopathies;¶~~
~~(M) Dichorionic, diamniotic twins;¶~~
~~(N) Monochorionic, diamniotic twins;¶~~
~~(O) Known fetal anomalies that require medical attention at birth;¶~~
~~(P) Two cesarean sections without previous successful vaginal birth;¶~~
~~(Q) Three cesarean sections with a previous successful vaginal birth;¶~~
~~(R) Blood coagulation defect;¶~~
~~(S) Significant glucose intolerance unresponsive to dietary and exercise intervention;¶~~
~~(T) Gestational diabetes well controlled with diet or oral glycemic medications; and¶~~
~~(U) Primary herpes outbreak.¶~~
~~(b) INTRAPARTUM NON-ABSOLUTE RISK CRITERIA:¶~~
~~(A) No prenatal care or unavailable records;¶~~
~~(B) History of substance abuse during this pregnancy;¶~~
~~(C) Signs and symptoms of infection including but not limited to a temperature 100.4 degrees Fahrenheit or higher with adequate hydration in the mother;¶~~
~~(D) Labor or premature rupture of membrane from 35 to 36 weeks gestation;¶~~
~~(E) Frank and complete breech presentation, as determined by vaginal examination;¶~~
~~(F) Lack of adequate progress in second stage:¶~~
~~(i) Lack of adequate progress in vertex presentation is when there is no progress after a maximum of three hours in cases with full dilation, ruptured membranes, strong contractions and sufficient maternal effort; and¶~~
~~(ii) Lack of adequate progress in breech presentation is when there is no progress in descent after a maximum of one hour in cases with full dilation, ruptured membranes, strong contractions and sufficient maternal effort.¶~~
~~(c) MATERNAL POSTPARTUM NON-ABSOLUTE RISK CRITERIA:¶~~
~~(A) Signs and symptoms of infection;¶~~
~~(B) Any condition requiring more than 12 hours of postpartum observation;¶~~
~~(C) Retained placenta greater than two hours with no unusual bleeding;¶~~
~~(D) Evidence of urinary retention that cannot be resolved in an out-of- hospital setting; and¶~~
~~(d) INFANT NON-ABSOLUTE RISK CRITERIA:¶~~
~~(A) Apgar less than 7 at five minutes without improvement;¶~~
~~(B) Weight less than 2,270 grams (five lbs.);¶~~
~~(C) Failure to void within 24 hours or stool within 48 hours from birth;¶~~
~~(D) Excessive pallor, ruddiness, or jaundice at birth;¶~~
~~(E) Any generalized rash at birth;¶~~
~~(F) Birth injury such as facial or brachial palsy, suspected fracture or severe bruising;¶~~
~~(G) Baby with signs and symptoms of hypoglycemia unresolved in the out-of-hospital setting;¶~~
~~(H) Weight decrease in excess of 10 percent of birth weight that does not respond to treatment;¶~~

~~(I) Maternal-infant interaction problems;¶~~
~~(J) Direct Coomb's positive cord blood;¶~~
~~(K) Infant born to HIV positive mother;¶~~
~~(L) Suspected or evident major congenital anomaly;¶~~
~~(M) Estimated gestational age of less than 35 weeks;¶~~
~~(N) Maternal substance abuse identified postpartum; and¶~~
~~(O) Cardiac irregularities, heart rate less than 80 or greater than 160 (at rest) without improvement, or any other abnormal or questionable cardiac findings.¶~~
~~(6) For the purpose of this rule "transfer of care" means the process whereby any LDM who has been providing care relinquishes this responsibility to a hospital or to licensees under ORS Chapter 682.¶~~
~~(a) The LDM must provide the following at the time of transfer, to the hospital or licensees under ORS Chapter 682: medical history, prenatal flow sheet, diagnostic studies, laboratory findings, and maternal and baby care notes through time of transfer;¶~~
~~(b) In cases of emergency, at the time of transfer, the LDM must provide the records required in subsection (a) to the hospital or licensees under ORS Chapter 682, including notes for care provided during the emergency, if available. If notes are not available, an oral summary of care during the emergency must be made available to the hospital or licensees under ORS Chapter 682; and¶~~
~~(c) Under no circumstances shall the midwife leave the mother or baby until such a time that transport is arranged and another Oregon licensed health care provider or a licensee under ORS Chapter 682 assumes care.¶~~
~~(7) For the purpose of this rule "consultation" means a dialogue for the purpose of obtaining information or advice from an Oregon licensed health care provider who has direct experience handling complications of the risk(s) present, as well as the ability to confirm the non-absolute risk, which may include, but is not limited to confirmation of a diagnosis and recommendation regarding management of medical, obstetric, or fetal problems or conditions. Consultation may be by phone, in person or in writing.¶~~
~~(8~~(1) Recognizing the importance of collaborative maternal health care, when determining the appropriateness of community birth, an LDM must assess risks, including ongoing and cumulative risks, by using clinical skills and expertise, relevant state rules and laws, principles of informed choice, midwifery core competencies, the setting of practice and access to higher levels of care, and careful consideration of selection criteria.¶
(2) When an indication to transfer presents the LDM must transfer care. If the mother or newborn present with any of the following indications the LDM must: ¶
(a) During the antepartum period, plan for transfer of care and an in-hospital birth; ¶
(b) During the intrapartum period, arrange transportation to the hospital and transfer of care unless the birth is imminent;¶
(c) When the birth is imminent, take the health and condition of the mother and baby and conditions for transport into consideration in determining whether to proceed with out-of-hospital birth or to arrange for transportation to a hospital and transfer of care; ¶
(d) During the postpartum period arrange for transfer of care.¶
(3) The timing for when arranging transportation and transfer of care in subsection (2) of this rule must occur is tied to the degree of risk of the indication to transfer. ¶
(4) If a client refuses transfer of care, the midwife must terminate midwifery care. The timing for when termination of care must occur is tied to the degree of risk of the indication to transfer. The LDM may immediately terminate midwifery care orally and then provide written notice to the client or relinquish care to a licensee under ORS 682.¶
(5) After transferring care, an LDM may continue to provide supportive care to the client including, but not limited to, nutritional advice, education, emotional, and psychosocial support.¶
(6) Upon documented resolution of an indication to transfer, an LDM may resume primary care and responsibility for the client or newborn, or both, and proceed with midwifery care.¶
(7) Indication to transfer - Pre-existing and historical conditions:¶
(a) Active cancer.¶

(b) Active or chronic renal disease.¶
(c) Acquired immune deficiency syndrome (AIDS).¶
(d) Four (4) or more cesarean sections.¶
(e) Diabetes currently requiring oral medication or insulin.¶
(f) Mother presenting with a previous classical uterine incision, T-incision, prior uterine rupture or extensive transfundal surgery. ¶
(g) Three (3) cesarean sections without previous successful vaginal birth.¶
(8) Indication to transfer - Antepartum:¶
(a) Hypertension at or above 140 systolic or at or above 90 diastolic on two (2) separate occasions that are more than four (4) hours apart, or hypertension at or above 160 systolic or at or above 110 diastolic on one (1) occasion.¶
(b) Deep venous or any treated thromboembolic disease.¶
(c) Active substance abuse.¶
(d) Ectopic pregnancy.¶
(e) Any pregnancy with abnormal fetal surveillance testing including, but not limited to, biophysical profile, non-stress test and auscultated acceleration testing.¶
(f) Acquired Immune Deficiency Syndrome (AIDS).¶
(g) Multiples.¶
(h) Hemoglobin under nine (9) unresponsive to treatment at term.¶
(i) Evident or suspected placenta accreta.¶
(j) Pregnancy lasting longer than 43 weeks 0 days gestation (21 days past the due date).¶
(k) Placenta less than 2.0 centimeters from internal os not resolved by onset of labor and as determined by ultrasound evidence.¶
(9) Indication to transfer - Intrapartum:¶
(a) Hypertension at or above 140 systolic or at or above 90 diastolic on two (2) separate occasions that are more than four (4) hours apart or hypertension at or above 160 systolic at or above 110 diastolic on one (1) occasion.¶
(b) Two (2) temperatures at 100.4 degrees Fahrenheit or 38 degrees Celsius or greater at two (2) intervals within one (1) hour or one (1) temperature at 102.2 degrees Fahrenheit or 39 degrees Celsius or greater.¶
(c) Signs and symptoms of complete or partial placental abruption.¶
(d) Vital sign instability or altered level of consciousness unresponsive to treatment.¶
(e) Persistent inability to auscultate fetal heart tones.¶
(f) Excessive vomiting, dehydration, acidosis or exhaustion unresponsive to treatment.¶
(g) Signs and symptoms of uterine rupture.¶
(h) Prolapsed cord or cord presentation.¶
(i) Retained placenta.¶
(j) Signs and symptoms of placenta previa or suspected placenta previa.¶
(k) Evident or suspected footling or kneeling breech and birth is not imminent.¶
(l) Active genital herpes in the vaginal, perineal, or vulva areas when the mother is in labor or has ruptured membranes.¶
(m) Signs and symptoms of shock.¶
(n) Signs and symptoms of chorioamnionitis or suspected chorioamnionitis.¶
(o) Labor or premature rupture of membrane less than 36 and 0 weeks gestation.¶
(p) Thick meconium stained amniotic fluid and birth is not imminent.¶
(q) Persistent non-reassuring fetal status.¶
(r) Lack of adequate progress in second stage in breech presentation, which means no progress in descent after a maximum of one (1) hour of active pushing in cases where the mother is fully dilated and has ruptured membranes.¶
(s) Lack of adequate progress in second stage with cephalic presentation, which means no descent after a maximum of three (3) hours of active pushing in cases where the mother is fully dilated and has ruptured

membranes.¶
(t) Transverse or oblique lie at onset of labor.¶
(u) Significant hemorrhage unresponsive to treatment with or without sustained vital sign instability or shock.¶
(10) Indication to transfer - Postpartum:¶
(a) Signs and symptoms of uterine infection.¶
(b) Pre-eclampsia or eclampsia.¶
(c) Laceration requiring transfer of care for repair including but not limited, to 3rd and 4th degree lacerations.¶
(d) Increasingly painful or enlarging hematoma.¶
(e) Significant hemorrhage unresponsive to treatment with or without sustained vital sign instability or shock.¶
(f) Postpartum depression or mood disorder with suspicion of possible endangerment of self or others.¶
(11) Indication to transfer - Newborn Care:¶
(a) Apgar less than seven (7) at 10 minutes of age.¶
(b) Persistent nasal flaring, grunting or retraction after one (1) hour of life without improvement.¶
(c) Seizures.¶
(d) Apnea.¶
(e) Central cyanosis.¶
(f) Persistent inability to maintain temperature between 97 to 100 degrees Fahrenheit or 36 to 37 degrees Celsius. ¶
(g) Persistent projectile or bilious vomiting or emesis of fresh blood.¶
(h) Evident or suspected infection.¶
(i) Significant distended abdomen.¶
(j) Weight less than 2,270 grams (five pounds.)¶
(k) Jaundice at birth or in the first 24 hours.¶
(l) Unresolved pallor at birth.¶
(12) "Indication for Consult" means a condition or clinical situation that places a mother or newborn at increased obstetric or neonatal risk but does not automatically exclude a mother and newborn from a community birth.¶
(13) When a mother or newborn present with one (1) or more indications for consult the LDM must:¶
(a) Arrange for transfer of care; or¶
(b) Comply with all the following:¶
(A) Consult with an Oregon licensed health care provider, as defined in OAR 332-025-0021(16) and (17), who is experienced and knowledgeable about the indication for consult unless a different Oregon licensed health care provider is otherwise stated specifically within this rule;¶
(B) Communicate to the mother the recommendations given by the consulting Oregon licensed health care provider if the mother was not present at the consultation;¶
(C) Obtain informed consent in accordance with OAR 332-025-0120;¶
(D) Make a plan with the mother about the indication; and¶
(E) Document the recommendations, consultation, discussion, informed consent and plan.¶
(14) Indication for Consult - Preexisting or historical medical conditions:¶
(a) Current treatment with prescription medication for any ongoing or chronic medical conditions.¶
(b) Cardiac condition.¶
(c) Active or chronic liver disease.¶
(d) Hyperthyroidism.¶
(e) Pulmonary disease being currently treated or is symptomatic.¶
(f) Hypertension at or above 140 systolic or at or above 90 diastolic outside of pregnancy.¶
(g) Deep venous thrombosis or any treated thromboembolic event.¶
(h) Previous myomectomy.¶
(i) Family history of thrombophilia.¶
(j) Placental abruption with adverse outcomes.¶
(k) One (1) or two (2) cesarean sections without previous successful vaginal birth.¶

(l) Three (3) cesarean sections with a previous successful vaginal birth.¶
(m) Psychiatric disorders with concern for maternal and fetal safety.¶
(n) Thrombophlebitis.¶
(o) Hemoglobinopathies.¶
(p) Preterm pre-eclampsia.¶
(q) Isoimmunization to blood factors.¶
(r) Syphilis.¶
(s) Human Immunodeficiency Virus (HIV) positive mother.¶
(t) Previous myomectomy. ¶
(u) Fetal demise.¶
(v) Bleeding disorder.¶
(w) Preterm delivery less than 34 weeks.¶
(x) Obstetric hemorrhage requiring transfusion.¶
(15) Indication for consult - Antepartum:¶
(a) Incomplete spontaneous abortion.¶
(b) Hemoglobin under 10 unresponsive to treatment.¶
(c) Oligohydramnios or polyhydramnios.¶
(d) Primary genital herpes.¶
(e) Second or third trimester bleeding.¶
(f) Abnormal fetal cardiac rate or rhythm.¶
(g) Abnormally decreased fetal movement.¶
(h) Uterine anomaly.¶
(i) Substance use disorder.¶
(j) Platelet count of less than 115,000.¶
(k) Isoimmunization to blood factors.¶
(l) Known fetal anomalies that may require medical attention.¶
(m) Psychiatric disorders with concern for maternal and fetal safety.¶
(n) Thromboembolic event.¶
(o) Gestational diabetes or blood glucose dysregulation well-controlled with diet and exercise.¶
(p) Syphilis.¶
(q) Human Immunodeficiency Virus (HIV) positive mother.¶
(r) Hemoglobinopathies. ¶
(s) Confirmed or suspected cholestasis.¶
(t) Breech presentation after 36 weeks. Consult for breech presentation after 36 weeks must be with a physician who provides cesarean delivery.¶
(u) Thrombophilia.¶
(16) Indication for consult - Intrapartum:¶
(a) A mother presenting with hypertension at or above 140 systolic or at or above 90 diastolic during labor or birth.¶
(b) Frank or complete breech identified in labor and without previous consult unless birth in imminent.¶
(17) Indication for consult - Postpartum:¶
(a) Hypertension at or above 150 systolic or at or above 100 diastolic on two (2) separate occasions which are more than four (4) hours apart or hypertension at or above 160 systolic or at or above 110 diastolic on one (1) occasion.¶
(b) Evident or suspected infection unresponsive to treatment.¶
(c) Ongoing or unresolved urinary retention.¶
(18) Indication for consult - Newborn:¶
(a) Failure to urinate within 24 hours after birth or pass stool within 48 hours after birth.¶
(b) Excessive ruddiness at birth.¶

(c) Any generalized rash at birth.¶
(d) Birth injury such as facial or brachial palsy, suspected fracture or severe bruising.¶
(e) Weight loss greater than 10 percent of birth weight that does not respond to treatment.¶
(f) Direct Coomb's positive. Consultation for Direct Coomb's positive newborns must be with a pediatric care provider.¶
(g) Newborn with Human Immunodeficiency Virus (HIV)-positive mother. Consultation for a newborn with Human Immunodeficiency Virus (HIV)-positive mother must be with a pediatric care provider.¶
(h) Evident or suspected major congenital anomaly.¶
(i) Evident or suspected neonatal opioid withdrawal syndrome.¶
(j) Pulse oximeter reading of less than 90 percent on right hand at greater than 24 hours.¶
(k) Heart rate less than 80 or greater than 160 (at rest) without improvement.¶
(l) Persistent cardiac murmur.¶
(m) Persistent poor feeding.¶
(n) Persistent hypotonia.¶
(o) Gestational age assessment of less than 36 weeks and 0 days.¶
(p) Respiration rate greater than 100 within the first two (2) hours postpartum, and greater than 80 thereafter, lasting more than one (1) hour without improvement.¶
(q) Evident or suspected abnormally elevated bilirubin.¶
(19) For the purpose of this rule "consultation" means a dialogue for the purpose of obtaining information or advice, with an Oregon licensed health care provider who has direct experience handling complications of the risk(s) present, as well as the ability to confirm the indication for consult, which may include, but is not limited to confirmation of a diagnosis and recommendation(s) regarding management of medical, obstetric, or fetal problems or conditions. Consultation may be by phone, in person, or in writing.¶
(20) For the purpose of this rule "Oregon licensed health care provider" means a physician or physician assistant licensed under ORS 677, a certified nurse midwife or nurse practitioner licensed under ORS 678, a naturopath licensed under ORS 685, or a licensed direct entry midwife licensed under ORS 687.
Statutory/Other Authority: ORS 676.601<u>5</u>, ~~676.615,~~ORS 687.480, ORS 687.48<u>0</u>5
Statutes/Other Implemented: ORS ~~676.605, 676.615,~~ 687.480, ORS 687.48<u>0</u>5

AMEND: 332-025-0130

RULE SUMMARY: Align termination of care rule with current practice.

CHANGES TO RULE:

332-025-0130
Practice Standards for Terminating Midwifery Care ¶

(1) The procedure for terminating midwifery care in a non-emergent situation is as follows: ¶
(a) Provide written notice no fewer than three business days as postmarked, unless the mother is in labor or during an emergency, at which time the LDM must continue to provide midwifery care until another provider assumes care; ¶
(b) Notice must be sent to the last known address of the mother by certified mail, return receipt requested, as well as by regular mail.¶
(c) Document the termination of care in the mother's records. ¶
(2) To terminate midwifery care in an emergency, the LDM must activate the 911 emergency system and transfer care to a licensee under ORS Chapter 682. ¶
(3) An LDM ~~in the home setting~~ may leave after transferring care to a licensee under ORS Chapter 682. ¶
(4) If the mother refuses assistance from licensees under ORS Chapter 682 the LDM must continually urge the mother to transfer care to a licensee under ORS Chapter 682 and may: ¶
(a) Continue care to save a life; and ¶
(b) Only perform actions within the technical ability of the LDM.~~¶~~
~~(5) If the mother loses consciousness, the LDM must activate the 911 emergency system and transfer care to a licensee under ORS Chapter 682.~~
Statutory/Other Authority: ORS 4676.615, ORS 687.4805, ~~676.615~~ORS 687.480
Statutes/Other Implemented: ORS 687.4205, ORS 687.480~~, 687.485, 676.606, 676.607~~