**OREGON HEALTH AUTHORITY**

**HEALTH LICENSING OFFICE, STATE BOARD OF DIRECT ENTRY MIDWIFERY**



## DIVISION 15

## DEFINITIONS & ICENSING

**332-015-0000**

**Definitions**

The following definitions as used in OAR 332-015-0000 through 332-030-0000:

(1) "Antepartum" and "prenatal" means the period of time from conception to the onset of labor.

(2) "Board" means the State Board of Direct Entry Midwifery.

(3) "Community birth" means birth in a home or birth center.

(4) "Intrapartum" means the period of time from the onset of labor through the birth of the placenta.

(5) "LDM" means a licensed direct entry midwife.

(6) "MANA" means the Midwives Alliance of North America.

(7) "MEAC" means the Midwifery Education and Accreditation Council.

(8) "NARM" means the North American Registry of Midwives.

(9) "Newborn" means a child less than one month of age.

(10) "Office" means Health Licensing Office.

(11) "Postpartum" means the period of time immediately after and up to eight weeks following a women giving birth.

(12) “Traditional Midwife” pursuant to ORS 687.415, means an individual who is acting as a traditional midwife, does not use legend drugs and devices, does not advertise as a midwife, and provides the required disclosures to clients who practices direct entry midwifery in Oregon without a license to practice direct entry midwifery.

(13) “Transfer of care” or “transfer care” means the process whereby any LDM who has been providing midwifery care relinquishes responsibility to 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, emergency services personnel under ORS 682, or a

hospital.

**332-015-0025**

**Direct Entry Midwifery License**

(1) A direct entry midwife licensed under ORS 687.420 may perform direct entry midwifery services defined under 687.405.

(2) A direct entry midwife license is active for one year and becomes inactive on the last day of the month one year from the date of issuance.



**332-015-0030**

**Application Requirements**

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

(a) Meet the requirements of OAR 331 Division 30;

(b) Submit a completed application form prescribed by the Office, which

must contain the information listed in OAR 331-030-0000 and be accompanied by the required application and license fees;

(c) Submit proof of being currently certified in cardiopulmonary resuscitation for infants and adults pursuant to ORS 687.420;

(d) Submit proof of being currently certified in neonatal resuscitation;

(e) Submit a written plan for emergency transport for mother or newborn pursuant to OAR 332-025-0020; and

(f) Submit proof of having current Certified Professional Midwife credential from NARM.

(2) In addition to the requirements listed in subsection (1) of this rule and pursuant to ORS 687.420, an applicant must show proof of having participated in:

(a) 25 deliveries as an assistant;

(b) 25 deliveries as the primary care provider;

(c) 100 prenatal care visits, 25 newborn examinations, and 40 postnatal examinations.

(d) 20 deliveries where continuity of care was provided as an

assistant or primary care provider. The continuity care must include four prenatal visits, one newborn examination, and one postpartum exam for each of the 20 deliveries.

(3) Of the 50 births listed in subsection (2) of this rule, at least 25 deliveries must have taken place as a community birth and 10 births must have occurred within the two years before the date of application.

(4) For the purpose of this rule, experience must have been obtained in one of the following ways:

(a) As an Oregon licensed health care practitioner while the services provided were within the scope of the practitioner's license;

(b) As a traditional midwife providing services in Oregon pursuant to ORS 687.415(2)(b);

(c) As an individual supervised by an LDM; or

(d) Under other lawful means.

(5) If the applicant received the Initial Legend Drugs and Devices continuing education prior to applying for licensure, it must have been obtained within two years before the date of application. If applicant receives the continuing education within 12 months of applying for licensure, the applicant must attest to having received the continuing

education at the time of next renewal on a form prescribed by the Office.

(6) If the applicant has not received the Initial Legend Drugs and Devices continuing education listed under OAR 332-020-0010(2) or (3) at the time of application this information must be disclosed to each patient on the patient disclosure form required under OAR 332-025-0020.

**332-015-0080**

**License Display and Posting Requirements**

(1) A LDM must show proof of valid license or post the license document in public view at the LDM's primary workplace.

(2) A LDM must carry the license identification card (pocket card), or post the official license in plain view anytime services are being provided.

**OREGON HEALTH AUTHORITY**

**HEALTH LICENSING OFFICE, STATE BOARD OF DIRECT ENTRY MIDWIFERY**

**DIVISION 20**

**~~R~~RENEWAL AND CONTINUING EDUCATION REQUIREMENTS**

**332-020-0000**

**License Issuance and Renewal**

(1) LICENSING: An LDM is subject to the provisions of OAR Chapter 331, division 30 regarding the issuance and renewal of a license, and provisions regarding authorization to practice, identification, and requirements for issuance of a duplicate license.

(2) LICENSE RENEWAL: To avoid delinquency penalties, license renewal must be made prior to the license entering inactive status. To renew, an LDM must:

(a) Submit renewal application form;

(b) Submit payment of renewal fee;

(c) Attest to having obtained required continuing education under OAR 332-020- 0010, on a form prescribed by the Office;

(d) Attest to being currently certified in cardiopulmonary resuscitation for infants and adults pursuant to ORS 687.425;

(e) Attest to being currently certified in neonatal resuscitation;

(f) Attest to having reported all births where the LDM was the primary midwife to MANAstats database pursuant to OAR 332-020-0017; and

(g) Attest to having participated in peer review pursuant to 332-025-0015.

(3) INACTIVE LICENSE RENEWAL: A license may be inactive for up to three years. When renewing after entering inactive status the LDM must:

(a) Submit renewal application form;

(b) Submit payment of renewal and delinquency fees;

(c) Attest to having obtained required continuing education under OAR 332-020- 0010, on a form prescribed by the Office, whether license is current or inactive;

(d) Attest to being currently certified in cardiopulmonary resuscitation for infants and adults pursuant to ORS 687.425;

(e) Attest to being currently certified in neonatal resuscitation;

(f) Attest to having reported all births where the LDM was the primary midwife to MANAstats database pursuant to OAR 332-020-0017; and

(g) Attest to having participated in peer review pursuant to 332-025-0015.

(4) EXPIRED LICENSE: An LDM that has been inactive for more than three years is expired and the licensee must reapply and meet the requirements listed in OAR 332-015-0030.

**332-020-0010**

**Continuing Education**

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

(2) In addition to the requirements listed in section (1) of this rule five (5) of the 35 hours must be related to legend drugs and devices pursuant to OAR Chapter 332 Division 26, which must include at least one (1) of the following:

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

(b) Administration of medications through injection;

(c) Advanced treatment of shock;

(d) Intravenous therapy;

(e) Suturing.

*(3) Initial Legend Drugs and Devices Continuing Education:* An LDM must complete 40 hours of instruction in an approved curriculum prior to purchasing or administering legend drugs and devices listed in OAR Chapter 332 Division 26 of these rules or by the date of first renewal following initial licensing as an LDM. The initial continuing education is comprised of theory, hands-on practice, and skills testing for competency which must include:

(a) 10 hours in pharmacology, covering drugs listed in ORS 687.493, OAR Chapter 332 Division 26 including;

(b) Four (4) hours of administration of medications through injection;

(c) Four (4) hours in advanced treatment of shock;

(d) 12 hours in intravenous therapy;

(e)10 hours in suturing.

(4) In addition to the requirements listed in subsection (1) of this rule and in accordance with ORS 687.425, an LDM who has attended fewer than five births in the previous renewal year must obtain an additional 10 hours of continuing education separate from all other continuing education requirements. The additional 10 hours of continuing education must be obtained during the next license renewal cycle. The additional 10 hours of continuing education must be related to subjects listed in subsection (1) of this rule. An example pertaining to the timing of when the additional 10 hours of continuing education must be obtained is: An LDM who held a license from April 2018 to April 2019 who attended fewer than five births during that time period must obtain an additional 10 continuing education hours between April 2019 and April 2020.

(5) Continuing education may be obtained through online courses, attendance at lectures, sessions, courses, workshops, symposiums seminars or other presentations offered by:

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

(g) Institutions or programs approved by the Oregon Higher Education Coordinating Commission;

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

(i) Any Board-approved professional organization, or association, hospital, or health care clinic offering continuing education related to subject matter listed above.

(6) 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) Up to 10 hours of continuing education relating to subject matter listed in subsection (1) of this rule may be completed through self-study that may include clinical service learning. Documentation substantiating the completion of continuing education through self-study must be submitted on forms provided by the Office.

(8) 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 Office. Adequate proof of participation is listed under OAR 332-020-0015(3).

(9) Hours of continuing education that are obtained in excess of the minimum requirements listed in this rule will not be carried forward.

(10) Documentation of participation in continuing education requirements must be maintained for five (5) years following renewal and must be available to the Office upon request.

(11) 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) A copy of Board-approved curriculum objectives for legend drugs and devices program is available at the Health Licensing Office or on the Office website. Payment of administrative fees may be required. Refer to OAR 331-010-0030 for applicable public record request fees.

(13) Requirements listed under OAR 332-020-0000 cannot be used towards the continuing education requirements listed in this rule.

**332-020-0015**

**Continuing Education: Audit, Required Documentation and Sanctions**

(1) The Office will audit a select percentage of licenses determined by the Board to verify compliance with continuing education requirements.

(2) An LDM notified of selection for audit of continuing education attestation must submit to the Office, within 30 calendar days from the date of notification, satisfactory evidence of participation in required continuing education in accordance with OAR 332-020-0010.

(3) If selected for audit, an LDM must provide documentation of the required continuing education, which may include:

(a) Certificate of completion, official transcript, statement or affidavit from the sponsor attesting to attendance or other documentation approved by the Office;

(b) Name of sponsoring institution, association, or organization;

(c) Title of presentation and description of content;

(d) Name of instructor or presenter;

(e) Date of attendance and duration in hours; and

(f) Course agenda.

(4) If documentation of continuing education is incomplete, the licensee has 30 calendar days from the date of the notice sent to licensee to submit further documentation to substantiate having completed the required continuing education.

(5) An LDM notified of having been selected for an audit must show proof of having:

(a) Participated in peer review pursuant to OAR 332-025-0015;

(b) The required certification in cardiopulmonary resuscitation for infants and adults;

(c) The required certification in neonatal resuscitation;

(d) Reported all births pursuant to OAR 332-020-0117.

(6) Documentation listed in subsection (5) of this rule must be kept and maintained for five years following renewal and must be available to the Office upon request.

**332-020-0017**

**Reporting Requirements**

In accordance with ORS 687.425, for renewal of a license an individual licensed as an LDM must attest to having submitted data on every mother and newborn electronically to the MANAstats database on any form prescribed by MANA, and in accordance with the policies and procedures established by MANA.

**OREGON HEALTH AUTHORITY**

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

**DIVISION 25**

**PRACTICE STANDARDS**

**332-025-0015**

**Peer Review and Sentinel Events**

(1) Pursuant to ORS 687.480, an LDM must participate in peer review.

(2) "Peer review" means the candid review and evaluation, subject to ORS 41.675, of midwifery practice. The objective of peer review includes: reviewing the provision of care, making recommendations for quality improvement, and identifying areas where additional education or skills training is needed.

(3) An LDM must participate in at least two peer review sessions per year, regardless of the number of births attended.

(4) Each peer review must be conducted with at least two other LDMs, one of which must be outside the LDM's practice.

(5) Each peer review must be conducted with providers who perform community births.

(6) At least one peer review session per year must be conducted by an entity consisting of more than five LDMs that review the quality of professional midwifery care provided by the LDM.

(7) An LDM who has had one of the following sentinel events must have the sentinel event reviewed within 90 days of the event by the entity described under subsection (6)

of this rule:

(a) Maternal hospitalization for infection;

(b) Maternal hospitalization requiring blood transfusion;

(c) Uterine rupture;

(d) Maternal or neonatal death;

(e) Neonate admitted to Neonatal Intensive Care Unit within 72 hours (except for observation or anomaly); or

(f) Transports deemed emergent by the LDM.

**332-025-0020**

**General Practice Standards**

(1) An LDM must include the designation LDM after their name when completing birth certificates.

(2) In accordance with ORS 687.480 and 687.493, an LDM must maintain equipment and appropriate legend drugs and devices necessary to assess maternal, fetal and newborn well-being.

(3) An LDM must adhere to all Center for Disease Control and Prevention standards, including disposing of waste and sharps that come in contact with blood or other potentially hazardous materials.

(4) An LDM must dispose of pathological waste resulting from the birth process in accordance with the Oregon Health Authority, Public Health Division under OAR 333 Division 56 including incineration of pathological waste.

(5) An LDM must comply with local government requirements as it relates to burial on private property.

(6) Pursuant to ORS 687.480, an LDM must maintain a "patient disclosure form" that provides current and accurate information to prospective clients. An LDM must provide the client with this information. The patient disclosure form must include, but is not limited to:

(a) Services provided to mother and newborn;

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

(c) Responsibilities of the mother and her family;

(d) Fees for services including financial arrangements;

(e) Malpractice coverage;

(f) A copy of risk assessment criteria as listed in OAR 332-025-0021. Risk criteria may be provided electronically or hard copy;

(g) If the LDM has obtained legend drugs and devices; and

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

(7) An LDM must maintain a written plan for emergency transport and must discuss the plan with the mother pursuant to ORS 687.480.

(8) The LDMs records must include the dated signature of mother documenting discussion of emergency transport plan.

(9) An LDM must maintain complete and accurate records documenting the course of midwifery care as listed under OAR 332-025-0110.

(10) An LDM must register all births with the Oregon Health Authority, Public Health Division, Center for Health Statistics as provided in ORS Chapter 432 and OAR Chapter 333 Division 011.

**332-025-0021**

**Risk Assessment Practice Standards**

(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 terminate midwifery care pursuant to OAR 332-025-0130.

(3) 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 a community birth.

(4) Pre-existing and historical conditions that require transfer of care:

(a) Active cancer;

(b) Active or chronic renal disease;

(c) Acquired immune deficiency syndrome (AIDS);

(d) Four (4) or more cesarean sections;

(e) Diabetes requiring oral medication or insulin;

(f) Mother presenting with a previous classical uterine incision, T-incision, prior uterine rupture or extensive transfundal surgery; and

(g) Three (3) cesarean sections without previous successful vaginal birth.

(5) Antepartum – Medical conditions that require transfer of care:

(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); and

(k) Placenta less than 2.0 centimeters from internal os not resolved by onset of labor and as determined by ultrasound evidence.

(6) Intrapartum – Medical conditions that require transfer of care:

(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 greater at two (2) intervals within one (1) hour or one (1) temperature at 102.2 degrees Fahrenheit 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) 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) Evident or suspected complete or partial placental abruption;

(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, perennial, 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; and active pushing; and

(t) Transverse or oblique lie at onset of labor.

<u>(7) Postpartum – Medical conditions that require transfer of care:</u>

(a) Retained placenta;

(b) Pre-eclampsia or eclampsia;

(c) Laceration requiring referral of care for repair including but not limited, to 3$^{rd}$ and 4$^{th}$ degree lacerations;

(d) Increasingly painful or enlarging hematoma;

(e) Significant hemorrhage unresponsive to treatment with or without sustained vital sign instability or shock; and

(f) Postpartum depression or mood disorder with suspicion of possible endangerment of self or others.

(8) Newborn Care – Medical conditions that require transfer of care:

(a) Apgar less than seven (7) at 10 minutes of age;

(b) 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;

(c) Persistent nasal flaring, grunting or retraction after one (1) hour of life without improvement;

(d) Seizures;

(e) Apnea;

(f) Central cyanosis;

(g) Persistent inability to maintain temperature between 97 to 100 degrees Fahrenheit;

(h) Persistent projectile or bilious vomiting or emesis of fresh blood;

(i) Evident or suspected infection;

(j) Significant distended abdomen;

(k) Weight less than 2,270 grams (five pounds.);

(l) Jaundice at birth; and

(m) Unresolved pallor at birth.

(9) "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.

(10) 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 appropriate Oregon licensed health care provider, in accordance with OAR 332-025-0021(16) and (17), who is experienced and knowledgeable about the indication for consult unless a different 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.

(11) Preexisting or historical medical conditions that require consultation:

(a) Actively being treated with prescription medication for any medical condition;

(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 or any treated thromboembolic disease;

(h) Previous myomectomy;

(i) Family history of thrombophilia;

(j) Placental abruption;

(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; and

(x) Obstetric hemorrhage requiring transfusion.

(12) Antepartum – Medical condition that require consultation:

(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 disease or thrombophilia;

(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; and

(t) Breech presentation after 36 weeks. Consult for breech presentation after 36 weeks must be with a physician who provides cesarean delivery.

(13) Intrapartum – Medical conditions that require consultation:

(a) A mother presenting with hypertension at or above 140 systolic or at or above 90 diastolic during labor or birth; and

(b) Frank or complete breech identified in labor and without previous consult.

(14) Postpartum – Medical conditions that require consultation:

(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; and

(c) Ongoing or unresolved urinary retention.

(15) Newborn – Medical conditions that require consultation:

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

(f) Direct Coomb's positive. Consult for Direct Coomb's positive must be with a pediatrician;

(g) Infant born to Human Immunodeficiency Virus (HIV)-positive mother. Consult for an infant born to Human Immunodeficiency Virus (HIV)-positive mother must be with a pediatrician;

(h) Evident or suspected major congenital anomaly;

(i) Evident or suspected neonatal abstinence syndrome or withdrawal;

(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; and
(o) Gestational age assessment of less than 36 weeks and 0 days.

(16) 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.

(17) 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.

**332-025-0022**

**Mother and Newborn Care Practice Standards**

(1) The Office and Board adopt by reference the MANA core competencies dated

August 4, 2011. A copy can be obtained from the Office.

(2) An LDM may:

(a) Order and receive laboratory and ultrasound results; and

(b) Order and receive fetal surveillance testing and results.

(3) Care during pregnancy (antepartum) — the LDM must:

(a) Provide a mechanism that ensures 24-hour coverage for the midwifery practice; and

(b) Begin fetal surveillance testing no later than 41 weeks and three days by arranging one (1) or more of the following:

(A) Biophysical profile weekly and non-stress test twice weekly;

(B) Biophysical profile weekly and auscultated acceleration testing twice weekly;

(C) Amniotic fluid index and non-stress test twice weekly; or

(D) Amniotic fluid index and auscultated acceleration testing twice weekly.

(c) If the mother declines, or the LDM is denied access to fetal surveillance testing in subsection (b) of this rule, the LDM must provide auscultated acceleration testing twice weekly beginning 41 weeks and 3 days until delivery. The LDM must use Board-approved practice for auscultated acceleration testing which can be obtained from the Office.

(A) If the mother declines fetal surveillance, follow OAR 332-025-0022(7).

(B) If the LDM is denied access to fetal surveillance testing, the LDM must document the place, date, time, and name of the individual who denied access in the mother's records.

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

(a) During active labor, evaluate the fetal heart rate at least every 30 minutes, listening continuously during and after contractions or more frequently if indicated;

(b) Auscultate fetal heart tones approximately every 5 to 15 minutes or after every contraction, as indicated, with active pushing; and

(c) Before the LDM leaves the LDM must:

(A) Deliver the placenta and assess and address any abnormalities and the mother's general condition including, but not limited to, blood pressure, pulse, temperature, fundus, lochia, and ability to ambulate and urinate;

(B) Assess and address abnormalities in the newborn's general condition including, but not limited to temperature, respirations, heart rate, feeding;

(C) Provide the family with written and verbal postpartum instructions.

(5) Care After Delivery (Postpartum Care) — The LDM must assess causes of, evaluate and treat problems arising during the postpartum period, consulting as necessary.

(6) Newborn Care — The LDM must:

(a) Adhere to state guidelines for the administration of vitamin K and ophthalmic prophylaxis pursuant to ORS 433.306 and OAR 333-021-0800; and

(b) Ensure infant metabolic screening is performed and documented according to the

Department of Human Services recommendations unless the mother declines, as provided in ORS Chapter 432 and OAR 333-024-1000 through 333-024-1110.

(7) Declined Procedure: In the event the mother refuses any testing or procedures required by administrative rule or recommended by the LDM, the LDM must document the LDM's discussion with the mother of why the test or procedure is required or recommended and document the mother's refusal, including obtaining the mother's signature in the chart. In addition, the LDM must follow the requirements of ORS Chapter 432 and OAR 333-024-1000 through 333-024-1110 when the mother declines administration of vitamin K or infant metabolic screening.

**332-025-0110**

**Records of Care Practice Standards**

(1) The LDM must maintain complete and accurate records of each mother and newborn.

(2) Records mean written or electronic documentation, including but not limited to:

(a) Midwifery care provided to mother and newborn;

(b) Demographic information;

(c) Medical history;

(d) Diagnostic studies and laboratory findings;

(e) Emergency transport plan OAR 332-025-0021;

(f) Informed consent and risk information documentation under OAR 332-025-0120;

(g) Health Insurance Portability and Accountability Act (HIPAA) releases;

(h) Documentation of all consultations pursuant to OAR 332-025-0021 (10) and recommendations regarding indications for consultation from an Oregon licensed health care provider as defined under OAR 332-025-0021(17), or any other provider specifically identified in OAR 332-025-0021;

(i) Documentation of any declined procedures OAR 332-025-0022(7);

(j) Documentation of termination of care (OAR 332-025-0130); and

(k) Documentation that the mother received the patient disclosure form (OAR 332-025-0020).

(3) Records, including metadata, must be maintained for no less than five years. All records are subject to review by the Office.

(4) All entries must include the LDM's initials and be legibly written or typed and dated.

(5) Entries made 48 hours after an event must be identified as an amended entry and must include the date and time of entry and the LDM's initials.

(6) All records must include a signature or initial of the LDM.



**332-025-0130**

**Practice Standards for Terminating Midwifery Care**

(1) The procedure for terminating midwifery care in a non-emergent non-indication to transfer situation is:

(a) Provide written notice to the client no fewer than three (3) business days prior to termination date.

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

(2) The procedure for terminating midwifery care for an indication to transfer for a preexisting condition, a historical condition, or during the antepartum period is:

(a) The LDM must transfer care. The timing for when transfer of care must occur is tied to the degree of risk of the indication to transfer. For emergency situations during the antepartum period, the LDM must follow subsection (6) of this rule.

(b) While arranging transfer of care, the LDM must provide any care necessary for the management and stabilization of the client until a complete transfer of care has occurred.

(c) 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. Notwithstanding subsection (1)(a), the LDM may immediately terminate midwifery care orally and then provide written notice to the client.

(3) The procedure for terminating midwifery care during the intrapartum period when there is an indication to transfer is:

(a) The LDM must immediately arrange transportation to the hospital and transfer care unless the birth is imminent:

(A) If the LDM cannot find immediate, safe transportation to the hospital, then the LDM must call 911.

(B) Regardless of a client's position regarding transportation to the hospital and transfer of care, the LDM must arrange transportation to the hospital and transfer care.

(C) If a client refuses transportation to the hospital and the LDM has not yet called 911, the midwife must call 911.

(D) The LDM must remain and provide any care necessary for the management and stabilization of the client or newborn, or both, until a complete transfer of care has occurred.

(b) When the birth is imminent, the LDM must take the health and condition of the client and fetus and conditions for transport into consideration in determining whether to arrange immediate, safe transportation to a hospital or to immediately call 911.

(A) Regardless of a client's position regarding transportation to the hospital and transfer of care, the LDM must arrange transportation to the hospital and transfer care.

(B) If a client refuses transportation to the hospital and the LDM has not yet called 911, the midwife must call 911.

(C) The LDM must remain with the client and provide any care necessary for the management and stabilization of the client or newborn, or both, until a complete transfer of care has occurred.



(c) The LDM must immediately inform the client that the midwife is required to arrange transportation to the hospital and transfer care because the risk to the client or fetus, or both, precludes out-of-hospital care;

(d) After having called 911, if the client refuses assistance from licensees under ORS chapter 682, the LDM may:

(A) Continue care to save a life; and

(B) Only perform actions within the technical ability and scope of the LDM.

(4) The procedure for terminating midwifery care during the postpartum period, including newborn care, when there is an indication to transfer is:

(a) The LDM must immediately arrange transportation to the hospital and transfer care of the client or newborn, or both:

(A) If the LDM cannot find immediate, safe transportation to the hospital, then the LDM must call 911.

(B) Regardless of a client's position regarding transportation to the hospital and transfer of care, the LDM must arrange transportation to the hospital and transfer care.

(C) If a client refuses transportation to the hospital and the LDM has not yet called 911, the midwife must call 911.

(D) The LDM must remain with the client and provide any care necessary for the management and stabilization of the client or newborn, or both, until a complete transfer of care has occurred.

(b) The LDM must immediately inform the client that the midwife is required to arrange transportation to the hospital and transfer care because the risk to the client or newborn, or both, precludes out-of-hospital care;

(c) After having called 911, if the client refuses assistance from licensees under ORS chapter 682, the LDM may:

(A) Continue care to save a life; and

(B) Only perform actions within the technical ability and scope of the LDM.

(5) The procedure for terminating midwifery care in any other emergency situation, is:

(a) The LDM must immediately call 911 and transfer care to a licensee under ORS Chapter 682.

(A) Regardless of a client's position regarding transportation to the hospital and transfer of care, the LDM must call 911.

(B) The LDM must remain and provide any care necessary for the management and stabilization of the client or newborn, or both, until a complete transfer of care has occurred.

(b) The LDM must immediately inform the client that the midwife is required to arrange transportation to the hospital and transfer care because the risk to the client or fetus, or both, precludes out-of-hospital care;

(c) After having called 911, if the client refuses assistance from licensees under ORS chapter 682, the LDM may:

(A) Continue care to save a life; and

(B) Only perform actions within the technical ability and scope of the LDM.

(6) Notwithstanding section (1)-(5), the procedure for terminating midwifery care when the client loses consciousness is that the LDM must immediately call 911 and transfer care to a licensee under ORS Chapter 682.

(a) The LDM must remain with and provide client any care necessary for the management and stabilization of the client or newborn, or both, until a complete transfer of care has occurred.

(7) Notwithstanding sections (2)-(6), the LDM has discretion to immediately call 911.

(8) Upon transfer of care, the LDM is no longer responsible for clinical care.

(a) An LDM may continue to provide supportive care to the client including, but not limited to, nutritional advice, education, emotional, and psychosocial support.

(b) The LDM may leave after transfer of care to a licensee under ORS Chapter 682.

(9) The LDM must document the termination of care in the client's records.

**OREGON HEALTH AUTHORITY**
**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, until the continuing education listed in OAR 332-020-0010 has been completed and attestation submitted to the Office upon renewal.

(2) Pursuant to ORS 687.493, an LDM who completes the continuing education listed in OAR 332-020-0010 is authorized to purchase and administer legend drugs and devices listed in OAR 332-026-0010, 332-026-0020, and 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 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 when 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 five years. Records must be kept on the business premises and available for inspection upon request by the 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.

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

(7) An LDM is required to obtain the continuing education for intravenous antibiotics for Group B Streptococcal prophylaxis, however an LDM is not required to administer the antibiotic.

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; DEM 2-2015, f. & cert. ef. 7-1-15

**332-026-0030**

**Approved Devices**

A LDM may use the following Board approved devices:

(1) Devices for injection of medications including:

(a) Needles; and

(b) Syringes.

(2) Devices for administration of intravenous fluids including:

(a) Drip sets; and

(b) Catheters.

(3) Devices for maternal and neonatal resuscitation including:

(a) Suction devices;

(b) Oxygen-delivery devices; and

(c) Bag-Valve-Mask-Sets.

(4) Devices for rupturing the amniotic sac.

(5) Devices for repairing the perineal area including:

(a) Sutures;

(b) Instruments for completing a repair; and

(c) Local anesthetic administration devices.

Stat. Auth.: ORS 183, 487.485 & 687.493
Stats. Implemented: ORS 183, 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 6-2010, f. 12-30-10, cert. ef. 1-1-11; Renumbered from 332-025-0060 by DEM 5-2011, f. & cert. ef. 9-26-11

**332-026-0010**

**Approved Legend Drugs For Maternal Use**

An LDM 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) Intravenous antibiotics for Group B Streptococcal prophylaxis is limited to the following and is only to be used solely for the purpose of Group B Streptococcal prophylaxis:

(a) Penicillin;

(b) Ampicillin;

(c) Cefazolin; or

(d) Clindamycin.

**332-026-0020**

**Approved Legend Drugs for Neonatal Use**

An LDM may administer the following legend drugs as approved by the board for neonatal use:

(1) Eye Prophylaxis for disease of the newborn is limited to Erythromycin Ophthalmic (0.5%) Ointment (Ilotycin, AK-Mycin and generics).

(2) Prophylaxis for hemorrhagic disease of the newborn for oral use is limited to Mephyton.

(3) Prophylaxis for hemorrhagic disease of the newborn for intramuscular injection includes:

(a) AquaMephyton; and

(b) Konakion.

(4) Resuscitation is limited to medical oxygen.

**332-040-0000**

**Fees**

(1) An applicant and licensee are subject to the provisions of OAR 331-010-0010 and 331-010-0020 regarding payment of fees, penalties and charges.

(2) Fees established by the Office pursuant to ORS 676.607 are as follows:

(a) Application:

(A) License: $150.

(B) License by reciprocity: $750.

(b) Examination — Oregon laws & rules: $50.

(c) Original issuance of license: $800 for one year.

(d) Renewal — License: $800 for one year;

(e) Reactivation of license: $150.

(f) Other administrative fees:

(A) Delinquency fee: $50 for each year in expired status up to three years.

(B) Replacement of license, including name change: $25.

(C) Duplicate license document: $25 per copy, with a maximum of three.

(D) Affidavit of licensure for reciprocity: $50.

(E) An additional $25 administrative processing fee will be assessed if a non-sufficient funds or non-negotiable instrument is received for payment of fees, penalties and charges. Refer to OAR 331-010-0010.

(4) As of July 1, 2015 an applicant applying for an original license totaling $800 may be granted a $350 license fee discount for a total cost for the license $450 until July 1, 2019. An application fee of $150 must be paid in order to grant the $350 license fee discount. The license fee discount is available to individuals who meet all application requirements for direct entry midwifery licensure under OAR 332-015-0030 and reside in Oregon. Only applicants who have not held a direct entry midwifery license in Oregon qualify for the discount.

(5) As of January 1, 2015, an applicant applying to renew a license totaling $800 may be granted a $200 discount for a total cost for the license $600 until July 1, 2019. The license fee discount is available to individuals who meet all renewal requirements for direct entry midwifery licensure under OAR 332-020-0000 and reside in Oregon.